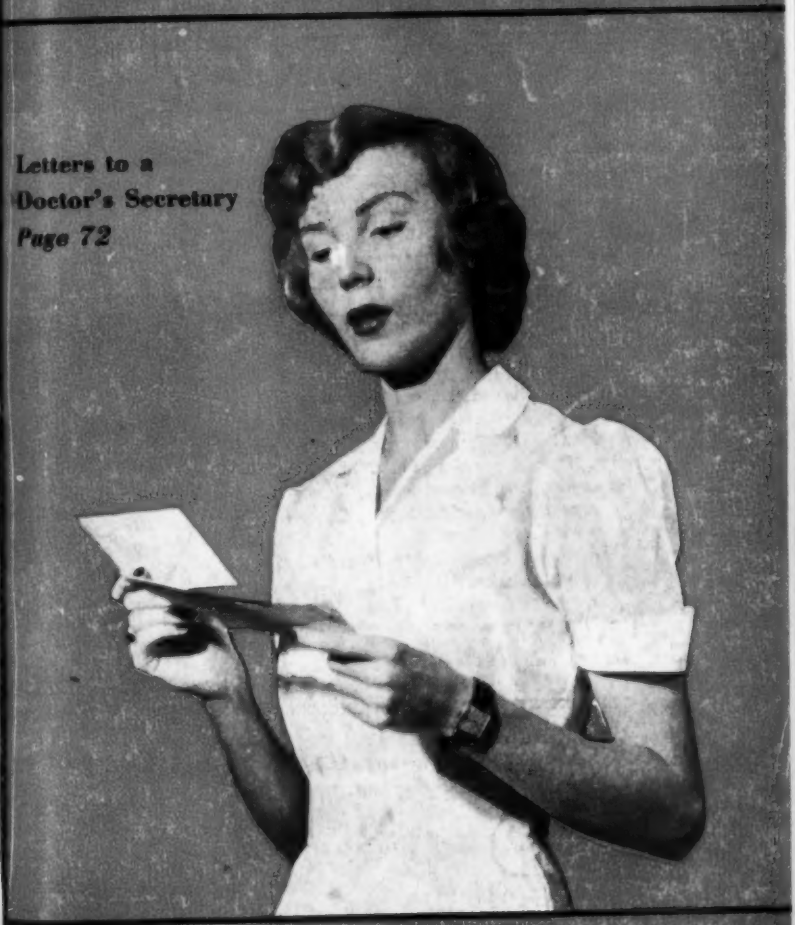
November **Medical Economics**



Letters to a Doctor's Secretary
Page 72

MERCODOL's distinctive antitussive brings

MORE COMPLETE RELIEF FOR YOUR COUGHING PATIENTS

Mercodol's selective cough-controlling narcotic[1] stops the wracking cough . . . but does *not* interfere with the cough reflex your patients *need* to keep passages clear. In addition, Mercodol provides an effective bronchodilator[2] to relax plugged bronchioles, and an expectorant[3] to liquefy secretions. The result is *more complete cough relief* . . . remarkably free from nausea, constipation, and cardiovascular or nervous stimulation.

MERCODOL®

An exempt narcotic

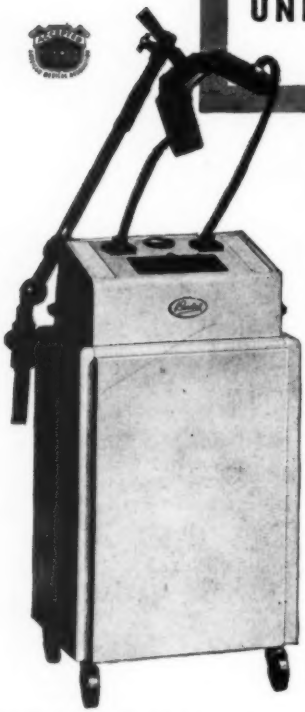
THE ANTITUSSIVE SYRUP THAT CONTROLS COUGH—**KEEPS** THE COUGH REFLEX

MERCODOL with **DECAPRYN**
For the cough with a specific allergic basis

Merrell
1828
New York • CINCINNATI • Toronto

Each 30 cc. contains:
1. Mercodinone® 10.0 m
2. Nethamine® Hydrochloride 0.1 Gr
3. Sodium Citrate 1.2 Gr
Trade-mark "Decapryn"

THE Burdick "MF-49" UNIVERSAL DIATHERMY



THE "MF-49" IS AN ALL-PURPOSE UNIT —

—adaptable to treatments with contour applicator (illustrated), induction cable, air-spaced electrodes, cuff technic and office electrosurgery.

THE "MF-49" IS ECONOMICAL —

— reasonably priced, no "extras," economical in operation.

THE "MF-49" IS POWERFUL —

— special type of frequency control permits full power tube output for heating large areas.

THE "MF-49" IS ACCEPTED —

— by A.M.A. Council on Physical Medicine and Rehabilitation; and approved by F.C.C. and the Underwriters Laboratories.

THE BURDICK CORPORATION

MILTON, WISCONSIN

THE WENDT-BRISTOL COMPANY

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NEW

FOR CLASS I, GROUP C LOCATIONS

UL

No. 4138-C

TOMPKINS PORTABLE ROTARY COMPRESSOR

fireproof and explosionproof

After years of research, Sklar engineers have developed the first suction, pressure and anesthesia apparatus which can be operated with safety in atmospheres containing ethyl-ether, cyclopropane and ethylene *(Class I, Group C Locations)*. The new Tompkins Portable Rotary Compressor has been approved—not merely for some of its individual components—but *as a complete unit* by Underwriters' Laboratories. *It is designed specifically for use where highly volatile anesthetic agents are used because of its provision for the dissipation of static electricity.* Another remarkable feature: *There's nothing to get out of order*—the only care required is lubrication! Complete details on request.

FEATURES

- *Heavy-duty, spring-suspended motor*
- *Quiet—vibrationless*
- *Suction and Pressure gauges with regulating valves*
- *2-way pressure by-pass valve*
- *Minimum care required*
- *Portable*

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Columbus, Ohio

A SKLAR PRODUCT

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Medical Economics

• • • *November 1951* • • •

[CONTINUED ON FOLLOWING PAGE]

Contents [*Continued*]

DEPARTMENTS

CCA

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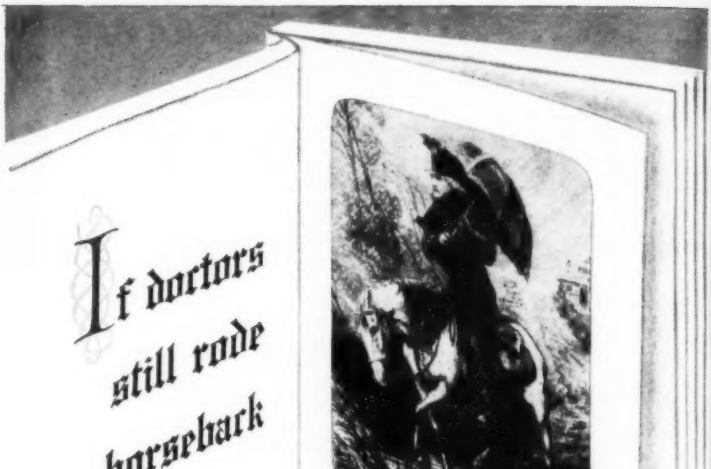
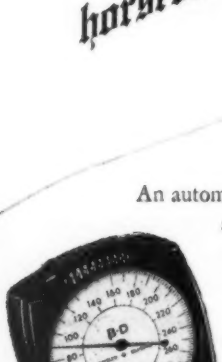
NBP



If doctors still rode horseback

An automobile has replaced Dobbin since the turn of the Century . . . but if doctors still made their calls on horseback, you'd find the B-D YALE ANEROID MANOMETER, Jeweled-Bearing, in many a saddle bag. Built in a *single integrated unit,* it is a *rugged* instrument that would withstand the bumps and jolts of a canter or a trot and give a lifetime of service.



Look for the red dot . . . it identifies the B-D YALE ANEROID MANOMETER *Jeweled Bearing*

- Greater sensitivity and dependability
- Greater precision and readability
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- Rugged construction

B-D PRODUCTS
Made for the Profession

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* Index of Advertisers *

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Only Castle gives you all 5 of these "extras" to save you time and expense

1. Heavy gauge steel cabinet looks, feels, and *is* sturdy—good-looking for years of growing practice

2. Cast aluminum base—no iron-rust marks on floors. Recessed for toe room

3. Wide-door opening. Easy to find and reach everything inside

4. Transparent glass shelves. Easy to see any item at once

5. Seamless interior. No dust-catching lips

In addition, the "95" has a cast-in-bronze lifetime boiler. It's "full automatic", of course. The price is right, too. So ask your Castle dealer about this fine cabinet sterilizer, or write:

WILMOT CASTLE CO.

1143 University Ave., Rochester 7, N.Y.

Castle LIGHTS AND STERILIZERS

the NEW therapy

in "functional G.I. distress"...

Decholin with Belladonna

Patients complaining of gastrointestinal distress without detectable organic cause are common problems in daily practice. By combining spasmolytic action with improvement in liver function, *Decholin/Belladonna*—in such cases—gives symptomatic relief by

reliable spasmolysis

hydrocholeretic flushing of biliary tract

improved blood supply to liver

mild, natural laxation without catharsis

While of special value in functional dyspepsia, *Decholin/Belladonna* is, of course, treatment of choice in biliary tract disorders for thorough and unimpeded flushing of the biliary system.

DOSAGE: One or, if necessary, two *Decholin/Belladonna* tablets three times daily after meals.

PACKAGING: *Decholin* (brand of dehydrocholic acid) *with Belladonna*, bottles of 100 tablets. Each tablet contains dehydrocholic acid 3¾ gr. and belladonna ¼ gr. (equivalent to tincture of belladonna, 7 minims).

Decholin, trademark reg.

AMES

AMES COMPANY, INC., ELKHART, INDIANA

AMES COMPANY OF CANADA, LTD., TORONTO

DB-1

Lift the depressed patient out of himself

A safe, ***two-fold lift*** for the convalescent, the aged, and the patient with psychic fatigue—in ***palatable Elixir Gerone.***

Two-fold because Gerone provides dextro-amphetamine sulfate, the antidepressant of choice . . . more potent[1, 2, 3] and less toxic[2, 4, 5] . . . plus vitamin supplementation, to combat nutritional inadequacy. Each teaspoonful (5 cc.) of Gerone contains: dextro-amphetamine sulfate, 2.0 mg.; thiamine hydrochloride, 2.0 mg.; nicotinamide, 10.0 mg.; riboflavin, 0.5 mg.; pyridoxine hydrochloride 0.5 mg.; calcium pantothenate, 1.0 mg.

Usual Dosage: One or two teaspoonfuls (5-10 cc.) three times daily immediately after meals.

Clinical Samples available on request.

1. Myersen, A.: J. Nerv. and Ment. Dis. *105*:598 (June) 1947.
2. Barnett, S. E.: Eye, Ear, Nose and Throat Monthly *29*:19 (January) 1950.
3. Schulte, J. W.; Reif, E. C.; Bacher, J. A. Jr.; Lawrence, W. S., and Tainter, M. D.: J. Pharmacol. and Exper. Therap. *71*:62-74 (Jan.) 1941.
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5. Gelvin, E. P., and McGavack, T. H.: New York State J. Med. *49*:279 (Feb. 1) 1949.

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An antidepressant with essential B vitamins

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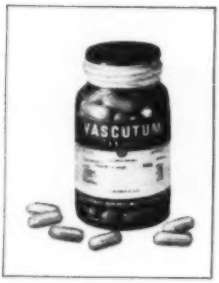
for the life that begins at forty

VASCUTUM* makes possible a dual attack—both prophylactic *and* therapeutic—in the two-front battle against hypercholesterolemia and capillary fragility. VASCUTUM combines in one medication:

- Potent amounts of lipotropic agents, to promote decholesterolization in atherosclerosis, cirrhosis and diabetes mellitus.
- Therapeutic amounts of rutin and ascorbic acid, to combat related capillary weakness effectively. Damaging retinal hemorrhage often results from excessive capillary fragility and associated abnormal cholesterol deposits.

A daily dose of 6 tablets provides:			
Choline	1 Gm.	Pyridoxine HCl	4 mg.
Inositol	1 Gm.	Rutin	150 mg.
dl-Methionine	500 mg.	Ascorbic Acid	75 mg.



VASCUTUM is another Schenley Laboratories contribution marking a distinct advance in the management of interrelated degenerative diseases clinically prominent in the middle-aged and elderly.

SUPPLIED in bottles containing 100 tablets.

SCHENLEY LABORATORIES, INC.
350 FIFTH AVENUE • NEW YORK 1

*The word VASCUTUM is a trademark of Schenley Laboratories, Inc.

Panorama

With higher taxes coming, professional management men are urging doctors to stress collections this year, postpone major expenses till next . . . Don't take all the mystery out of surgery, advises Sir Cecil Wakeley, president of Britain's Royal College of Surgeons; too much knowledge "transforms some patients into nervous wrecks" . . . Over 90 per cent of U.S. newspapers now oppose socialized medicine, reports Dr. John W. Cline, A.M.A. president.

To edge more students into general practice, nineteen medical schools now offer preceptorships where undergrads understudy near-by G.P.'s. Last year 713 students took such courses . . . North Carolina woman was awarded $1,500 for "humiliation and embarrassment" after Pittman Hospital kept her four extra days because of unpaid bill . . . American income today averages $1,436 for every man, woman, and child. Commerce Department reports these highs and lows: District of Columbia, $1,986; Delaware, $1,909; Nevada, $1,875; Arkansas, $825; Mississippi, $698.

Government pressing case against Dr. Louis F. Borow, Plainfield, N.J., who allegedly bought War Assets Administration drugs for $2,800, later sold them for $38,000 . . . Does your aide need training in filing, bookkeeping, office routine? Film Research Associates, New York, lists some 150 such movies and slide films for rent or loan . . . It still happens here: Elderly New York couple met Rumanian gypsy who promised to cure their ills. She prayed for them, burned candles—and fleeced them of $6,000 . . . Speaking on Denver radio station during Rocky Mountain Cancer Conference, Dr. W. Edward Chamberlain, Philadelphia, was startled to hear announcer describe him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For
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SEARL
XUM

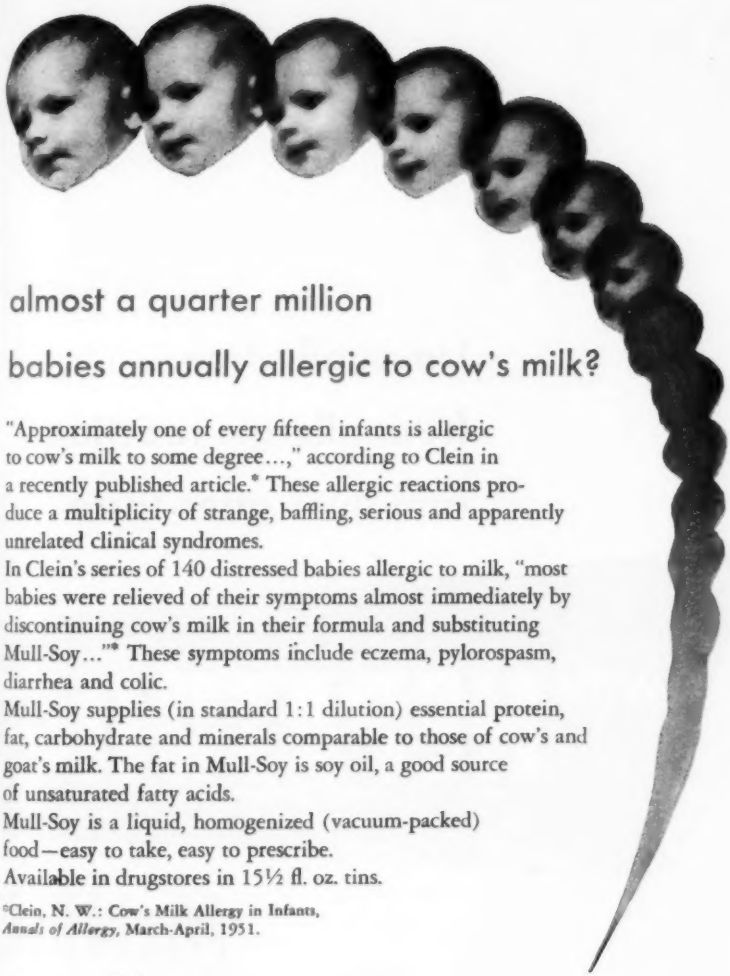
as "in no way related to the sponsor"—a hand-lotion manufacturer named Chamberlain.

Defense areas to get $60 million worth of new community facilities, including hospitals. Congress recently okayed the grant . . . In Los Angeles, Dr. Myron Prinzmetal suing Sid Grauman estate for $46,000 in fees. He treated the Hollywood showman's 1948 mental collapse . . . Using the doctor's own adhesive tape, three youths in Brooklyn bound Dr. Jacob Rosenbloom, his wife, and son, escaped with $500 plus jewelry . . . Detroit Medical News suggests new committee to advise doctors on spreading charity gifts wisely and well.

Bull market in people: World Health Organization reports world's population going up at 60,000-a-day clip. Current total, 2,378,000,000 . . . New York Academy of Medicine has answered N.Y. Times readers who claimed Polish immigrant couldn't have had her last child at 56. Academy says a 72-year-old woman holds record, but adds that births to mothers in their fifties and sixties are not rare in modern obstetrics.

Commercial agencies charging 45 per cent, on average, to collect doctors' delinquent accounts. So reports Stanley R. Mauck, Columbus (Ohio) Bureau of Medical Economics . . . Thefts of doctors' bags by drug addicts increasing. Three Kansas City M.D.'s in a row had bags lifted from their cars . . . Dr. J. Clarence Chambers Jr., becoming medical superintendent of city-owned James Ewing Hospital, is first Negro in New York history to get such a post . . . Dr. Robin C. Buerki, former University of Pennsylvania V.P., taking up new duties as director of Henry Ford Hospital, Detroit.

New novel of Dr. Frank G. Slaughter, "The Road to Bithynia," is about another physician with an even better-known by-line: St. Luke . . . Number of women medical students has declined for five straight years; they totaled only



almost a quarter million

babies annually allergic to cow's milk?

"Approximately one of every fifteen infants is allergic to cow's milk to some degree...," according to Clein in a recently published article.* These allergic reactions produce a multiplicity of strange, baffling, serious and apparently unrelated clinical syndromes.

In Clein's series of 140 distressed babies allergic to milk, "most babies were relieved of their symptoms almost immediately by discontinuing cow's milk in their formula and substituting Mull-Soy..."* These symptoms include eczema, pylorospasm, diarrhea and colic.

Mull-Soy supplies (in standard 1:1 dilution) essential protein, fat, carbohydrate and minerals comparable to those of cow's and goat's milk. The fat in Mull-Soy is soy oil, a good source of unsaturated fatty acids.

Mull-Soy is a liquid, homogenized (vacuum-packed) food—easy to take, easy to prescribe.

Available in drugstores in 15½ fl. oz. tins.

*Clein, N. W.: Cow's Milk Allergy in Infants, *Annals of Allergy*, March-April, 1951.

Mull-Soy first in

hypoallergenic diets for infants, children and adults

The **Borden** Company, Prescription Products Division, 350 Madison Avenue, New York 17

The answer is... a special process of enzymatic digestion

This process is the outstanding feature of Hepatinic's liver concentrate—it breaks down the proteins of liver, producing smaller, more easily absorbed molecules which have the same nutritional value as the liver protein before treatment.

During this process, certain of the vitamins are freed and made more readily available.

In addition to its unfractionated (crude) liver concentrate, Hepatinic contains iron in the most readily assimilable (ferrous) form, and the B vitamins—thiamine, riboflavin, niacinamide and B_{12}.

All these factors combine to make Hepatinic an unparalleled hematinic-nutritional-supplement which most patients, even those sensitive to other oral liver products, tolerate well.

The flavor of Elixir Hepatinic is so delightful that we'd like to have you try it—drop us a card for a tasting sample.

Also available in convenient Tablet form:—each sugar coated orange tablet containing the equivalent of 5 cc. (one teaspoonful) of the Elixir.

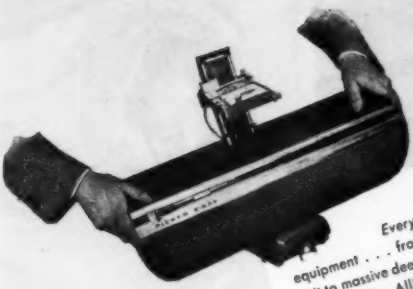
BORATORIES, INC.
ILADELPHIA 32, PA.

5 per cent of last freshman class . . . To tighten up on drunken drivers and end "ridiculous legal farce," Dr. Henry E. McGarvey, president of Westchester (N.Y.) Medical Society, seeks law that would (1) require scientific tests of accused driver's alcoholic content, (2) require courts to accept them as evidence . . . New head of the Division of Medical Opinion, Federal Trade Commission, is a non-physician. He's Frederick W. Irish, graduate pharmacist and chemist . . . More state medical societies adding field representatives, the latest being California (three) and North Carolina (one).

Thieves visited Dr. David Steinbaum's house in Bayonne, N.J., made off with $2,500, tried again two months later. Net haul on second call: $10 . . . Low mortality rate among American wounded in Korea (about half that of World War II) due largely to whole blood and plasma supplies, says Army Surgeon General George E. Armstrong . . . Credit Dr. Ian Stevenson of Louisiana State University with epigram-of-the-month: "Both public and practitioners must realize that it is less important to have a well-known physician than to be well-known by one."

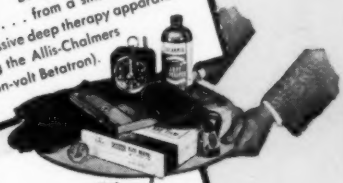
Comic books being used by New York State's mental hygiene department to put over mental health ideas . . . In Allegheny County, Pa., a G.P., rush-called to a butcher's sick wife, was paid usual fee plus a bonus: three pounds of choice sirloin steak . . . Free baths may be next gift on Britain's N.H.S. agenda. Proposal under consideration would let elderly invalids phone for a portable tub. Tub would arrive on a special truck, with hot and cold running water.

Ominous medical note from Pravda: Hundreds of young Soviet specialists being shifted to Kamchatka and Siberian coast—across from Alaska, flanking Japan . . . Fifteen Priority 1 physicians didn't show up as directed for July induction; Department of Justice now after them . . . Dim view dept.: Gallup pollsters find that 58 per cent of us expect World War III within five years.



apparatus

Everything in fine x-ray equipment . . . from a small portable unit to massive deep therapy apparatus (including the Allis-Chalmers 24 million-volt Betatron).



one source for everything in X-ray

supplies

Everything in fine x-ray supplies and accessories . . . from a few films to comprehensive large-scale installations . . . even a thermometer for blind darkroom technicians, should you want one.

layout

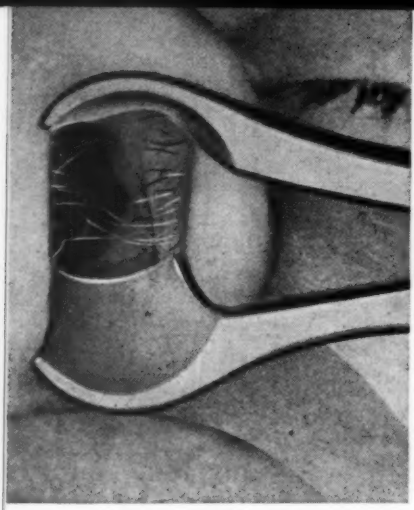
Everything in x-ray layout planning . . . and an expert engineering staff to help you with anything from a single room to whole floors.

service

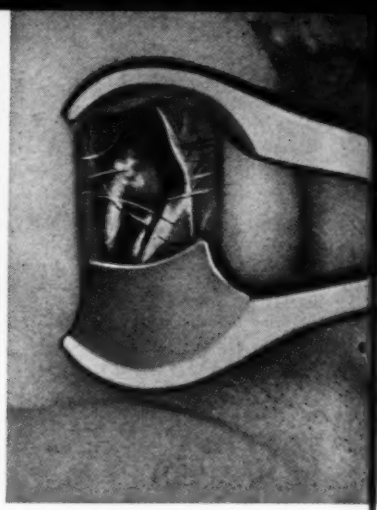
Everything in x-ray service and maintenance . . . through a trained corps of servicemen and engineers, and at strategic locations.

There's a Picker Sales Office and Service Depot near you, staffed by capable men eager to serve you well. Picker X-Ray Corp., 300 Fourth Avenue, N. Y. 10.

Picker x-ray



Before intranasal administration of Paredrine-Sulfathiazole Suspension.



After instillation of the Suspension in the Proetz—or head-low—position.

(*Photographs slightly enlarged.*)

These photographs show the advantages of a SUSPENSION in treating INTRANASAL INFECTIONS

Paredrine-Sulfathiazole Suspension—unlike antibacterial agents in *solution*—does not quickly wash away. It clings to infected areas for hours—assuring prolonged bacteriostasis. When instilled in the Proetz position, it reaches *al* of the sinal ostia, thus helping to prevent sinusitis.

Paredrine-Sulfathiazole Suspension is the most widely prescribed sulfonamide nose drop. No instances of sensitivity to its use have ever been reported.

Smith, Kline & French Laboratories, Philadelphia

Paredrine-Sulfathiazole Suspension

vasoconstriction in minutes . . . bacteriostasis for hours

'Paredrine' T.M. Reg. U.S. Pat. Off.

Speaking Frankly

Meetings

SIRS: Determined to take action on the problem of too many medical meetings, the president of a nearby medical society appointed six busy physicians as a "Medical Meetings Committee" to look into the matter.

If setting a good example means anything, these physicians did their part. Here, verbatim, is their annual report: "There have been no meetings of the Medical Meetings Committee; therefore, there is no report."

M.D., New Jersey

Undercut

SIRS: Recently I hospitalized a man who had out-of-state Blue Cross and Blue Shield coverage. His policy clearly stated that he was allowed $8.50 a day for a hospital room. So when he was told at the hospital that in South Carolina his policy would provide only $5.50 a day, he became indignant. With much effort and sweet talk, I persuaded him to take a ward bed temporarily, until we could straighten the matter out.

I took out his appendix—a procedure for which his policy clearly stated that $150 would be paid. Yet the check I eventually received was for only $100. I know this is the South Carolina Blue Shield rate; but this man had been paying premiums that warranted the higher operative fee and the more expensive hospital bed.

Do the prepay plans just pocket the difference?

Marion L. Mathias, M.D.
Columbia, S.C.

Retirement

SIRS: The problem of retirement plans for M.D.'s, currently being discussed in your pages, can be partly solved by including the doctors in Federal Social Security. I've heard all the arguments pro and con, and personally I'm much against Government bureaucracy. But while Social Security is on the books, I'm also much against discrimination. What's good for some people is good for all.

Charles S. Fox, M.D.
Southampton, Pa.

Dodo

SIRS: Is the E.E.N.T. specialist becoming extinct? There seems to be considerable pressure from both the ophthalmologists and otolaryngologists to limit practice to one or the other of those fields.

This specialization may be suit-

able for the larger cities, but is it in the best interests of the smaller towns? Many of them cannot support both an ophthalmologist and an otolaryngologist. If no provision is made to train men for both fields together, these communities will have difficulty finding E.E.N.T. specialists to serve them.

Of all surgical specialties, otolaryngology has been hardest hit by chemotherapy. Besides, other surgical specialties are constantly making inroads on its territory. The chest surgeon is doing endoscopy; the plastic surgeon is doing rhinoplastics; the tumor surgeon is claiming all head and neck tumors except intracranial lesions. In fact, since the decline of mastoid and sinus surgery, the average otolaryngologist's surgical practice is composed largely of tonsillectomies and submucuous septectomies.

In view of these facts, can a man in a town of even 10,000 limit his practice to ear, nose, and throat? Perhaps he could in the past. I doubt that he will be able to in the future. Yet the number of hospitals offering combined E.E.N.T. training is rapidly declining. Doctors have done too little to challenge this trend.

M.D., North Dakota

Giveaway

SIRS: Your article on professional courtesy especially interested me. Since I am a radiologist and since my practice is 100 per cent referred, I am confronted with this problem almost daily. My biggest headaches

are due to the following "courtesy" patients:

1. Doctors' parents who are financially independent.
2. Parents of doctors' wives.
3. Other relatives of doctors, down to distant cousins and in-laws.

I've tried discounts, but no matter how sizable the discount it never seems to satisfy the referring doctor. So to avoid even bigger headaches, I often just give my services away.

M.D., California

Emergencies

SIRS: For the past two years, emergencies have been my business. I was new in town and took such calls in the hope that they might lead to some permanent patients. But (except where people I know are involved) no more emergency calls for me!

Why did I give up making these calls? Consider the last five I went out on and judge for yourself:

¶ At 2 A.M. a man called in behalf of his neighbor, an elderly lady. "Doctor, she's dying," he said. I rushed to the address. The house was dark but I kept knocking. Finally a disheveled man opened the door and rasped, "What the heck do *you* want?" I explained I was the doctor to see Mrs. Jones. "Nobody called you, buddy. Mrs. Jones is sound asleep." The door banged in my face.

¶ Next call was from a woman: "Doctor, please hurry. My brother-in-law is paralyzed. It's because of a bullet that lodged in his spine when he was in the war." When I

Wyeth

YOUR DIABETIC PATIENT and FAULTY LIPID METABOLISM

- **The Problem**

It has long been recognized that many diabetics have a defective mechanism for metabolizing fats, especially if they are overweight and middle aged.[1]

- **Two-Sided Etiologic Picture**

Liver disease is generally secondary to diabetes . . . but sometimes liver dysfunction may aggravate the diabetic syndrome.[1]

- **Value of Lipotropic Therapy**

In the former case, lipotropic factors such as choline[2] and inositol[3] have been observed to reduce excessive blood cholesterol levels.

In the latter case, the patient's response to lipotropic therapy may so favorably influence the syndrome that insulin requirements are sharply reduced.[1-4]

- **In Every Case . . .**

The cardinal rule of lipotropic therapy is to give enough, long enough.

With Syrup WYCHOL It Is Easy

- To give enough—because WYCHOL is potent. One tablespoonful supplies 3 Gm. choline *base* plus 0.45 Gm. inositol.
- To maintain therapy—because WYCHOL has an appealing fruit-like flavor.
(It should be noted that each tablespoonful Syrup WYCHOL supplies 6.75 Gm. sucrose)

1. Leevy, C.M., Ryan, C.M., and Fineberg, J.C.: Am. J. Med. *8*:290, 1950.
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4. Dietrich, H.W.: South. M. J. *43*:743, 1950.

SUPPLIED: Syrup WYCHOL, bottles of 1 pint • Capsules WYCHOL, bottles of 100 and 1000—convenient for maintaining therapy away from home.

WYCHOL®

Choline and Inositol Wyeth

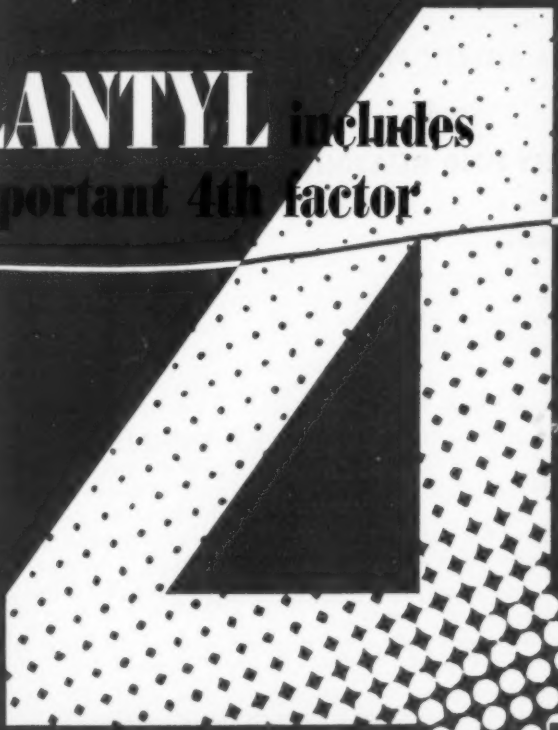
Wyeth Incorporated • Philadelphia 2, Pa.

Now...

"an improved method of therapy for peptic ulcer"[1]

only

KOLANTYL includes the important 4th factor



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1. ***To control hyperacidity***—a superior antacid combination (magnesium oxide and aluminum hydroxide, also a specific antipeptic) provides two-way, balanced antacid activity.

2. ***To control crater irritation***—a superior demulcent (methylcellulose, a synthetic mucin) forms a protective coating over ulcerated mucosa.

3. ***To control spasm***—a superior antispasmodic[2-4] (Bentyl Hydrochloride) provides direct smooth muscle and parasympathetic depressant properties . . . without "belladonna backfire."

4. ***To control lysozyme***—a proven antilysozyme, *sodium lauryl sulfate*. Recent evidence suggests that lysozyme, as well as pepsin and hydrochloric acid, is an etiologic factor in the pathogenesis of peptic ulcer . . .[5-7] It seems well established that sodium lauryl sulfate is capable of inhibiting the lysozyme and peptic activity of the gastric juice without changing its pH.[8-14]

DOSAGE: Two tablets every three hours as needed for relief. Mildly minted Kolantyl tablets may be chewed, or swallowed with ease. Kolantyl is also recommended for the hospitalized patient.

in the control of peptic ulcer

KOLANTYL

Merrell
1828
New York
CINCINNATI
Toronto

arrived a little breathless, the smiling wife told me her husband had just left for the nearest bar.

¶ One of those 3 A.M. calls—this time a woman's voice saying: "Hurry, I'm bleeding terribly." A few minutes later I was looking at a pretty blonde, cosily tucked in bed with a bottle of beer handy. No trace of hemorrhage, but she did have an explanation: "I was lonesome and couldn't sleep. I had to tell you *something* to get you to come."

¶ Fourth case was a man who had slipped at a party and broken two ribs. I taped him up and told him my fee was $10. "I call that highway robbery," he shouted. "You ought to be reported to the medical association." Since he was a wealthy oil executive, I didn't worry too much.

¶ The last call came in at 4 A.M. An ulcer, it seemed, was perforating. I found a young man, about 30, lying comfortably in bed. "My own physician told me I've got an ulcer that's perforating my pancreas," he explained. "I must have a tube of dilaudid." When I found there was no sign of perforation, I walked out.

Of course, if the county medical association should phone me and say no one else was available, I'd still make a call. But I've learned that emergencies are no good for building a practice. Too few of these people return to me; most of them wouldn't make good patients if they did.

I now leave emergency calls to

double *the power to resist food* in obesity!

Long-established habits of catering to an enormous appetite and the "love for eating" make the problem of weight reduction doubly difficult. It requires a strong will-power to adhere to a restricted dietary regimen day after day . . . for dietary restriction and lack of bulk create a gnawing sense of emptiness that impels violation of the diet. Bulk hunger, as well as excessive appetite, therefore, must be controlled.

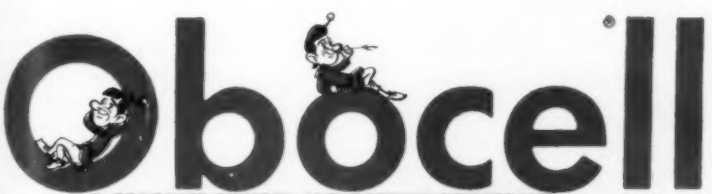
Based upon the modern concept of hunger and appetite, Obocell makes reducing easy. Obocell is a new therapeutic adjunct that curbs appetite, suppresses bulk hunger, elevates the mood and **doubles** the power to resist food.

Each Obocell tablet contains Dextro-Amphetamine Phosphate, 5 mg.; Methylcellulose, 150 mg. **Dose:** Three to six tablets daily, usually given 30 minutes before meals. **Supplied:** Bottles of 100, 500, 1000.

Literature and Samples on Request

IRWIN, NEISLER & COMPANY • Dept. ME • **DECATUR, ILLINOIS**

Research to Serve Your Practice



A COMBINED HUNGER AND APPETITE DEPRESSANT

younger men eager for adventure. I'm sure they'll find plenty.

Werner Bergmann, M.D.
Oakland, Calif.

Barriers

SIRS: My pet peeve is this: Why should the license to practice medicine be limited, more or less, by state boundaries? A motorist with a driving license issued by one state still has the privilege of driving in all other states. Why shouldn't this same freedom apply to medical practice, the qualifications for which are even more standardized?

Robert J. Critchlow, M.D.
Philadelphia, Pa.

Backward

SIRS: Believe it or not, in this era of allegedly modern medicine, anyone involved in a street accident in El Paso, Tex., (pop. 135,000) is practically cut off from emergency hospital service.

To begin with, no ambulance can be summoned to the accident scene without police authorization. Even if that vehicle arrives in time, it brings no medical aid. Nor can it transport the victim to any general or county hospital for emergency medical care. Reason: No hospital, general or county, maintains an interne or resident staff. What other communities know as emergency-room service just doesn't exist.

All El Pasoans can hope is that, in event of accident, they will be struck down near the William Beaumont Army Hospital. The commandant there recently assured the pub-

lic that twenty-four-hour emergency service would be open to them—provided the accident occurs in the neighborhood of the hospital.

M.D., Texas

Schemer

SIRS: Medical service for all *is* possible on a voluntary basis, and at a price every individual can afford—if each person's health insurance premiums are based on his taxable income. That's probably the most accurate indication of ability to pay.

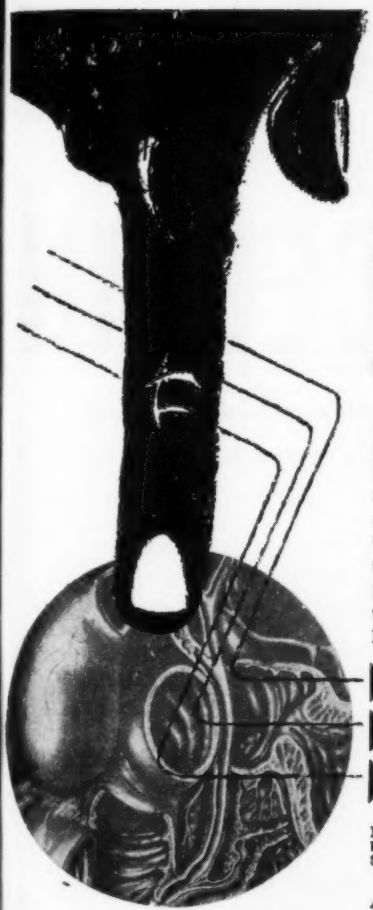
How to arrange it? Take the total cost of medical care, the total number of taxpayers, and their total tax. From these, figure out what each person should pay in relation to his income to provide sufficient funds. Then collect that premium along with his income tax, turning the health-fund money over to the voluntary plans.

Thus Government would not be running the health insurance plans, but only acting as tax collector—which is about all it's efficient at, anyway.

I. E. Phillips, M.D.
Johnson City, Tenn.

Collections

SIRS: Any M.D. who signs a contract with a commercial fee-collecting agency without studying *all* the fine print may find himself in trouble. I recently had an unhappy experience with one such agency. Its contract contained—in small print, of course—such clauses as: "There is a minimal charge of $3 for all ac-



the finger
of suspicion
points to

biliary disorders

...when the patient complains of flatulence, indigestion, constipation. Every other patient past age 40 suffers from some form of biliary disturbance,* investigators state. Caroid and Bile Salts Tablets offer simple, effective relief of dyspepsia, constipation and other distressing symptoms of biliary disorders. Functional restoration is aided by—

- stimulation of bile flow
- improved digestion and absorption of foods
- gentle laxation without whipping the bowel

Dosage: 1 or 2 tablets after breakfast and at bedtime with a glass of water.
Sample available on request

American Ferment Company, Inc.
1450 Broadway, New York 18, N. Y.

*Rahfuss, M. E.: Penna. Med. J. 42:1335, 1939.

CAROID AND BILE SALTS *tablets*

Specifically indicated in biliary dyspepsia and constipation

counts accepted, collected or uncollected; also a charge of 30 per cent of the amount of each account where full or partial payment has been recovered."

In other words, if the agency collects even $1 on a $100 account, the client will be charged 30 per cent of the *full* amount his debtor owes. Add in the $3 fee for each uncollectible account, and you may find that instead of receiving a fat check from the collection people, you *owe* them a substantial sum.

M.D., New York

Melodious

SIRS: My reception room offers "entertainment while you wait." A loudspeaker there is connected with a radio-phonograph and tape-recorder in another section of the house. I am able to pipe radio programs and recordings to my patients in subdued tones that do not interfere with conversation.

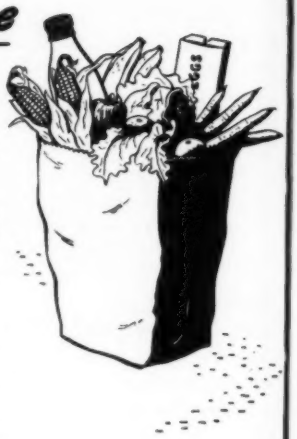
I have even put in some plugs against socialized medicine, first speaking them into the tape-recorder and then transmitting them over the loudspeaker.

Many patients have remarked that the music relieves the tedium of waiting. It serves also to direct attention away from consultation and treatment rooms. Although my offices are sound-proofed, every now and then a patient with a loud voice used to be overheard. Now music from the loudspeaker takes care of that.

J. F. Crane, M.D.
North Warren, Pa.

minerals

make the difference



"All dietary correction must include the simultaneous administration . . . of well balanced necessary substances."[1]

"For successful growth, and the maintenance of health, the diet must contain a suitable assortment of minerals in a total concentration of approximately 4 percent of the dry weight of food."[2]

The VITERRA formula includes a balanced assortment of the essential minerals and vitamins required for the maintenance of health.

1. Waife, S. O.; The Clinical Significance of the Interrelation of Nutrient Factors, Medical Clinics of North America, p. 1718, Nov., 1949.
2. Everett: Med. Biochem., Sec. Ed., Inorganic Substances, Gen. Factors in Mineral Metabolism, p. 568.

11 minerals

and trace elements

9 vitamins

ALL IN ONE

CAPSULE

Vi terra

Vitamin A	5,000 U.S.P. Units
Vitamin D	500 U.S.P. Units
Thiamine Hydrochloride	3 mg.
Riboflavin	3 mg.
Pyridoxine Hydrochloride	0.5 mg.
Niacinamide	25 mg.
Ascorbic Acid	50 mg.
Calcium Pantothenate	5 mg.
Mixed Tocopherols (Type IV)	5 mg.
Calcium	213 mg.
Cobalt	0.1 mg.
Copper	1 mg.
Iodine	0.15 mg.
Iron	10 mg.
Manganese	1 mg.
Magnesium	6 mg.
Molybdenum	0.2 mg.
Phosphorus	165 mg.
Potassium	5 mg.
Zinc	1.2 mg.

Available at all Pharmacies

J. B. ROERIG AND COMPANY, 536 LAKE SHORE DRIVE, CHICAGO 11, ILL.

ROERIG Rx

Positive patient response

to this blood-building, appetite-building iron tonic with B_{12} activity

plus... iron (ferrous gluconate) in tonic quantities

plus... essential B complex vitamins well in excess of known minimum daily requirements

plus... pleasant taste, too

ELIXIR CAPSULES

BETA-CONCEMIN FERRATED

IRON-B COMPLEX WITH B_{12} ACTIVITY

Beta-Concemin®

Merrell
1828

New York • CINCINNATI • Toronto

CONDEMNED!

Yes! Condemned to many weary years of indigestion, constipation, and — in all likelihood — more serious functional disorders! All's rosy now, but 40,000 hours of sitting may well change his disposition—slow the normal flow of bile . . . impair digestion and bowel function . . . and make the aftermath of every meal a tribulation.

To this patient, and to millions like him, ZILATONE® offers symptomatic relief and functional recovery. ZILATONE is a rational, fourfold formulation which combines the benefits of • *bile salts* • *mild laxatives* • *tonics* and • *digestants* — of tested efficacy. ZILATONE improves choleresis, stimulates bowel motility, and promotes the digestion, utilization, and enjoyment of food.

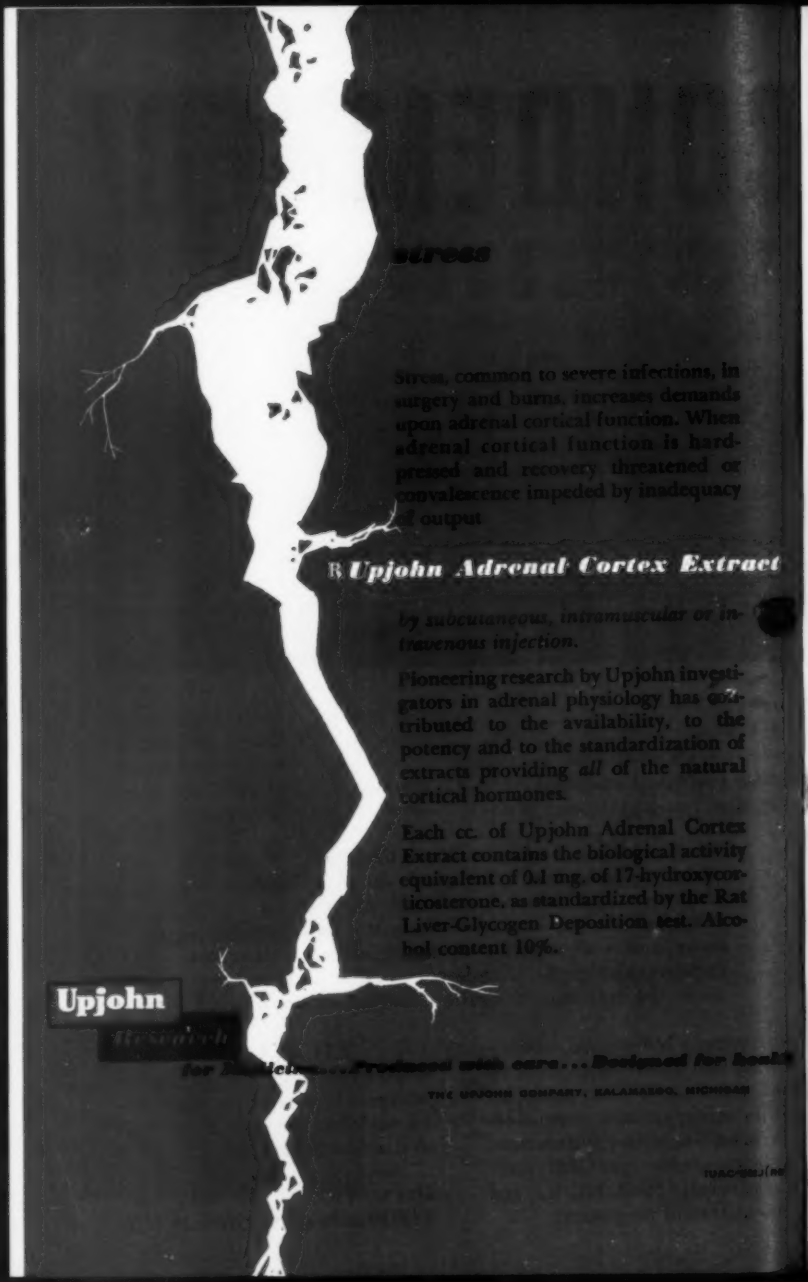
INDICATIONS: Indigestion, constipation, and faulty utilization of food, particularly when caused by biliary stasis; geriatric complaints attributable to biliary dysfunction; cholecystectomy (pre- and postoperatively); cholecystitis; and constipation of pregnancy.

ZILATONE®

SUPPLIED: Boxes of 20, 40, and 80 orange-colored tablets—each tablet sealed in sanitary tape. Also available in bottles of 500 and 1,000.

Samples to physicians on request.

Drew Pharmacal Co., Inc.
1450 Broadway, New York 18, N.Y.


stress
Stress, common to severe infections, in surgery and burns, increases demands upon adrenal cortical function. When adrenal cortical function is hard-pressed and recovery threatened or convalescence impeded by inadequacy of output
Upjohn Adrenal Cortex Extract
by subcutaneous, intramuscular or intravenous injection.
Pioneering research by Upjohn investigators in adrenal physiology has contributed to the availability, to the potency and to the standardization of extracts providing all of the natural cortical hormones.
Each cc. of Upjohn Adrenal Cortex Extract contains the biological activity equivalent of 0.1 mg. of 17-hydroxycorticosterone, as standardized by the Rat Liver-Glycogen Deposition test. Alcohol content 10%.
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Research
for Medicine...Produced with care...Designed for Health
THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

Sidelights

Industry Calling

Industrial medicine does not, perhaps, have the glamour of brain surgery, and the company doctor is less likely than the psychiatrist to become the hero of a Hollywood epic. Yet those who have made this their special field speak for the many satisfactions it affords.

The industrial physician works regular hours and is assured a regular income. He has no collection worries, makes practically no night calls, and has more time to spend with his family. It sounds like an overworked M.D.'s nirvana. Yet . . .

Industrial plants can't find the trained doctors needed to carry on adequate in-plant medical services. As a result, warns Dr. Howard A. Rusk, defense production is lagging. To meet defense requirements, the A.M.A. Council on Industrial Medicine estimates, we need at least 1,600 more industrial physicians.

The doctors needed won't come out of our schools, either. Though several excellent P.G. courses in industrial medicine are offered, some attract no students at all; others get only a handful. That puts it up to the men already in practice.

We have a hunch that some of these practitioners are overlooking a good bet. Many a company has just recently discovered that larger outlays on workers' health yield larger production returns. So the doctor who has something to offer industry today may well find that industry has even more to offer him.

Telephone Technique

One of the mysteries of medical practice is why a patient who appears satisfied with your treatment suddenly ups and starts going to another doctor. The reasons for switching are legion, of course; but we would point to one reason that some doctors overlook: their wives' way of handling telephone calls.

A woman we know recently told her doctor off on that score. He had come to the house to find little Janie with a bad case of tonsillitis. When he asked why he hadn't been called sooner, Janie's mother said crisply: "I *did* call—yesterday. Janie woke with a fever. When I telephoned around 8 o'clock, your wife said you were sleeping; she didn't want to disturb you unless it was really important. I argued with her for five minutes, but all she'd agree was to have you call me back later. Then, obviously, she forgot to tell

you about it. Believe me, if that new doctor in town hadn't been on vacation, *he'd* be taking care of Janie now."

In this instance, Janie's mother told the physician. Ordinarily, she's more likely to tell the women's club.

Lord knows it's hard to be obliging when telephoners call at 3 A.M. to find out if Junior is old enough to eat spinach. Yet it must be done. What's more, it *can* be done—as the wife of almost any successful pediatrician is well aware.

One such woman makes it a point to tell new mothers among her husband's clientele to phone about *anything* they want to know. "If it's worrying you," she says, "then it's important." When it's a simple question that she is qualified to answer, she does so. When it's an emergency, she tears the town apart till she finds the doctor.

If *your* spouse happens to need a good example, there it is.

Forbidden Word

Our profession has recently been urged to abandon the use of the term "layman," on grounds that it implies a division of all Gaul into two classes. Physicians and Lesser People.

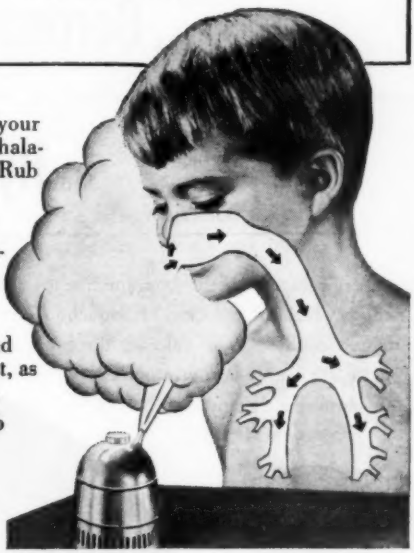
There is much merit in this idea; but rather than root out the word itself, we recommend bearing down on the unspoken attitude that sometimes lies behind it.

Mr. Brown, an intelligent adult who comes in complaining of stomach trouble," does not want to be

When you recommend

steam therapy *consider* **Vicks VapoRub**

as the medicament



You can increase the benefits your patients derive from steam inhalation by suggesting Vicks VapoRub as the medicament.

Its well-balanced formula contains not one but seven volatilizing ingredients, including menthol, thymol, camphor and oil of eucalyptus—all helpful in soothing the irritated mucosa of the respiratory tract, as well as in combatting dryness.

So consider Vicks VapoRub when your patients require steam therapy, whether you recommend a vaporizer or some other method. In practically every home, Vicks VapoRub is already on hand for instant use.

for your patients

We will be happy to send you a generous supply of distribution samples. Why not use this handy coupon?

VICK CHEMICAL COMPANY
Department S11, Box 1813
Greensboro, North Carolina

Please send me, without obligation, a supply of distribution samples of Vicks VapoRub.

Name_____

Street_____

City_____ State_____

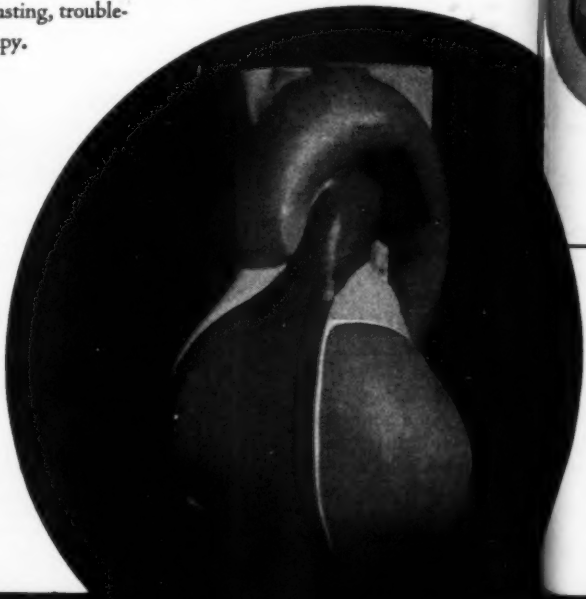
without distraction

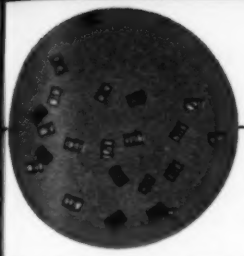
in Cardiac Decompensation

in Coronary Disease

in Hypertension

The superior features of theobromine therapy are now available without the side-effects which drive doctors to distraction. Maltbie research has produced an unique double salt of calcium theobromine and calcium gluconate—Calpurate, for longer lasting, trouble-free theobromine therapy.





Seeing is believing

Calpurate is *really* different. Convincing evidence may be seen at a glance in the accompanying polarized photomicrographs. Compare the rectangular crystals of theobromine (top), and the needle-like crystals of calcium gluconate (middle), with the double-salt crystals from a solution of Calpurate (bottom).

In clinical practice, too

Seeing is believing...

Calpurate affords sustained myocardial stimulation, vasodilation and diuresis without gastric disturbances. Calpurate with Phenobarbital relieves stress and improves circulatory efficiency, exerts a desired calming effect.

Administration and Dosage: 1 or 2 tablets t.i.d.

Maltbie Laboratories, Inc., Newark 1, New Jersey

Calpurate • Tablets and Powder

Theobromine Calcium Gluconate Maltbie

Calpurate

with **Phenobarbital** • Tablets

for trouble-free, prolonged cardiac therapy

told merely, "Get this prescription filled and come back in a week." What disease does he have? Is it serious? What is being done to him, and why? He resents the slightest suggestion—even an unconscious one—that his own, his very own illness, is none of his business.

The doctor who treats Brown as an active collaborator in the cure, rather than as a passive recipient, is pretty sure to get better results. What's more, he'll keep Brown longer as a patient.

No physician need worry about giving offense through use of the word "layman"—as long as his attitude shows he doesn't construe it to mean "ignorant," "stupid," or "dull."

Speaking of Fees

A Philadelphia doctor, while trying to decide what fee to charge for his services, spied a television set in the patient's living room.

"Nice-looking set," he said casually.

"Oh, we've got a much better one upstairs," the patient replied.

Result: The doctor doubled his fee.

This, we submit, is a good example of why the sliding scale of fees has fallen into some disrepute. Television sets, after all, are no indication of wealth—as witness the antenna-topped shanties along some of our main-line railroads.

Unless doctors can scale their fees according to some sound basis, we think they're often better off not to scale them at all.

A Significant Development in

COMPEN

A NEW PENICILLIN SALT

Compenamine, an entirely new penicillin compound, is the penicillin G salt of the levo isomer of N-methyl-1,2-diphenyl-2-hydroxyethylamine. Its generic name is *l*-ephenamine penicillin G. It is less soluble in water than is procaine penicillin, and its theoretical potency is 1,058 units per mg.

AS EFFECTIVE AS PROCAINE PENICILLIN G

The action of Compenamine, unit for unit, was found to be identical with that of procaine penicillin G against 73 strains of bacteria, six viruses, and five protozoa. Absorption and excretion curves are essentially the same for both penicillin salts, but longer blood levels are usually found with Compenamine.

SIGNIFICANT REDUCTION OF ALLERGIC REACTIONS

On the basis of extensive clinical experience,[1,2,3,4,5,6,7] Compenamine has been shown to be well tolerated even by patients sensitive to procaine penicillin G. In known reactors, in excess of 80 per cent can tolerate this salt without reaction. In over 1,000 cases, initial intradermal or topical use, followed by a large challenging dose 10 days later, *did not lead to induced sensitivity in a single instance.* In this series, only seven instances of allergic reactions were seen, less than one per cent. *Thus Compenamine greatly broadens the applicability of penicillin therapy.*

---

1. Longacre, A.B.: P-92 Penicillin; Report of a Very Low Reaction Rate in Therapy with a New Penicillin Salt, Antibiotics & Chemotherapy *1*:223 (July) 1951.
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PERSONAL COMMUNICATIONS

3. Lupton, A.: Presbyterian Hospital, New York.
4. Wooldridge, W.: Barnard Skin & Cancer Hospital, St. Louis.
5. Katz, S.: Gallinger Municipal Hospital, Washington, D.C.
6. Suskind, R.: Cincinnati General Hospital.
7. Finnerty, E.J., Jr.: Boston City Hospital.

Penicillin Therapy....

ENAMINE

INDICATIONS

Compenamine is indicated in the treatment of all conditions responding to penicillin. Since it is nearly insoluble in water and in oil, its dosage forms are of the repository type, leading to prolonged blood levels. Hence it makes possible once-a-day injection in most patients.

NO PRICE PENALTY TO YOUR PATIENTS

Compenamine costs no more than comparable dosage forms of procaine penicillin G, giving your patients all the advantages of this new penicillin salt without price penalty.

MERITS ROUTINE USE

Because it significantly reduces the incidence of allergic reactions, because its therapeutic efficacy is as great as that of procaine penicillin G, and because it imposes no price penalty, Compenamine merits routine use whenever a repository type of penicillin is called for.

AVAILABLE IN THREE DOSAGE FORMS

Compenamine is currently available in three repository dosage forms:

Compenamine (for aqueous injection), in vials.

Compenamine Aqueous, in vials and disposable and permanent syringe cartridges.

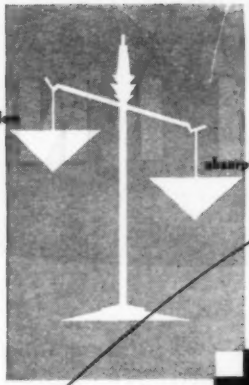
Compenamine in Peanut Oil, in vials and disposable and permanent syringe cartridges.

Other dosage forms will be announced shortly.

C.S.C. Pharmaceuticals

A DIVISION OF COMMERCIAL SOLVENTS CORPORATION, NEW YORK 17, N. Y.

THE FIRST PRODUCER OF CRYSTALLINE PENICILLIN G IN COMMERCIAL QUANTITIES



so adequate

There's a wide safety margin between the amount of menstrual flow* and the absorptive capacity of TAMPAX tampons—a fact strongly substantiated by the purchase of more than two billion TAMPAX in the past twelve years. The comfort and convenience of the three absorbencies of these dainty intravaginal cotton guards (with individual applicators) are also strongly appealing.

*Am. J. Obst. & Gyn., 31:979, 1936.

TAMPAX INCORPORATED · PALMER, MASS.

ACCEPTED FOR ADVERTISING BY THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

ME-111

TAMPAX

the internal menstrual guard of choice

Your request will bring professional samples promptly.

When the diagnosis is Pyelitis

To establish and maintain urinary antisepsis, MANDELAMINE* is many times preferred because it is quickly effective against the organisms most commonly encountered in urinary-tract infections. Its exceptional freedom from untoward reactions and its wide range of antibacterial activity commend it for use as soon as the diagnosis has been made.

Urinary antisepsis is often achieved in uncomplicated pyelitis in as few as three days. Speedy recovery is thus secured in many cases without necessitating higher-cost therapy.

Other indications for MANDELAMINE are cystitis, prostatitis, pyelonephritis, nonspecific urethritis, and infections associated with urinary calculi or neurogenic bladder; also valuable for pre- and postoperative prophylaxis in urologic surgery.

Renal insufficiency is the only major contraindication to MANDELAMINE therapy.

MANDELAMINE is available in bottles of 120, 500, and 1,000 enteric-coated tablets, through all prescription pharmacies. Comprehensive literature and samples for clinical trial will be furnished to physicians on request.

NEPERA CHEMICAL CO., INC.
Pharmaceutical Manufacturers
NEPERA PARK, YONKERS 2, N. Y.

*MANDELAMINE is the registered trademark of Nepera Chemical Co., Inc., for its brand of methenamine mandelate

Ready to use and in liquid form, Dextrogen is a concentrated infant formula, made from whole milk modified with dextrins, maltose, and dextrose. In addition, it is fortified with iron to compensate for the deficiency of this mineral in milk. Diluted with 1½ parts of boiled water,* it yields a mixture containing proteins, fats and carbohydrates in proportions eminently suited to infant feeding. In this dilution it supplies 20 calories per ounce.

The higher protein content of normally diluted Dextrogen—2.2% instead of 1.5% as found in mother's milk—satisfies every known protein need of the rapidly growing infant. Its lower fat content makes for better tolerability and improved digestibility. Dextrogen serves well whenever artificial feeding is indicated, and is particularly valuable when convenience in formula preparation is desirable.

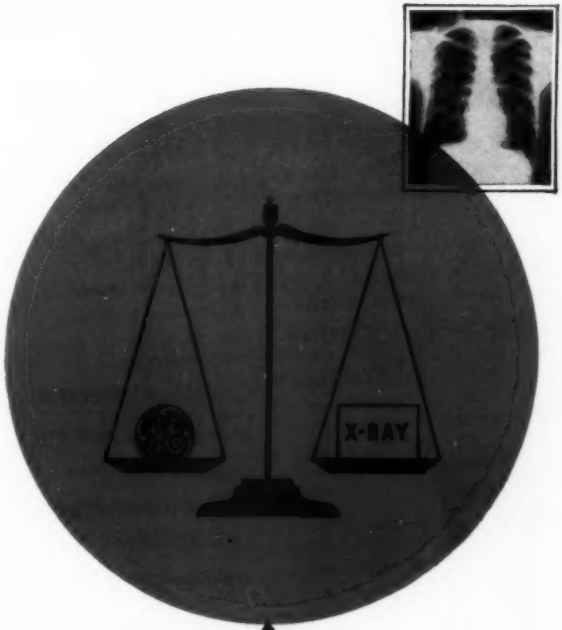
NOTE HOW SIMPLE TO PREPARE

All the mother need do is pour the contents of the Dextrogen can into a properly cleaned quart milk bottle, and fill with previously boiled water. Makes 32 oz. of formula, ready to feed.*

*Applicable third week and thereafter; 1:3 for first week, 1:2 for second week.

THE NESTLÉ COMPANY, INC.

COLORADO SPRINGS, COLORADO



GE quality is balanced quality

X-RAY

One standard for everything whether it is a bolt or a generator, whether it is hidden or in plain view, whether it costs ten cents or a hundred thousand dollars, General Electric standards admit no compromise with quality. As your profession dictates integrity of purpose — so we accept the responsibility for integrity in quality. For this reason . . .

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Management of pyogenic skin disorders . . .

'POLYSPORIN'® brand

Polymyxin B – Bacitracin OINTMENT

bactericidal to **BOTH** *gram-positive and gram-negative organisms, no local tissue damage, little likelihood of sensitization.*

For eliminating a very wide range of local infections.

For preventing contamination of burns, wounds, and skin grafts; such protection shortens healing time and reduces incidence of fever and local inflammation.[1]

1. Jackson, P. M., Lowbury, E. J. L., and Topley, E.: Lancet, 261:137, 1951.

Tubes of 15 Gm. (with blunt nozzle) ⅛ oz. (with ophthalmic nozzle)

Each gram of 'POLYSPORIN' OINTMENT contains:

'AEROSPORIN'® brand Polymyxin B (Sulfate) 10,000 Units
(Equivalent to 1 mg. Polymyxin Standard)
BACITRACIN 500 Units

Complete information will be sent on request

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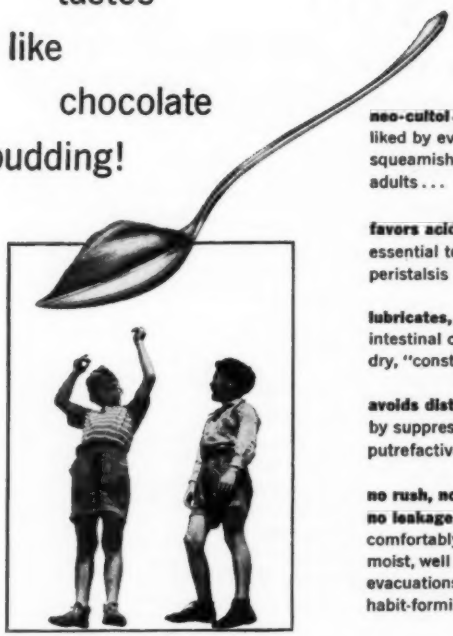
neo-cultol...

provides viable L. acidophilus which multiply rapidly in the colon, in a chocolate-palatable mineral oil jelly.

tastes
like
chocolate
pudding!



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liked by even
squeamish children and
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favors aciduric flora
essential to normal
peristalsis and daily regularity.

lubricates, softens
intestinal contents to prevent
dry, "constipated" feces.

avoids distressing flatulence
by suppressing
putrefactive bacteria.

no rush, no griping, no strain—no leakage
comfortably passed,
moist, well formed
evacuations—without harsh,
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L. Acidophilus in chocolate-flavored mineral oil jelly

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Wide-mouth jars of 6 oz.

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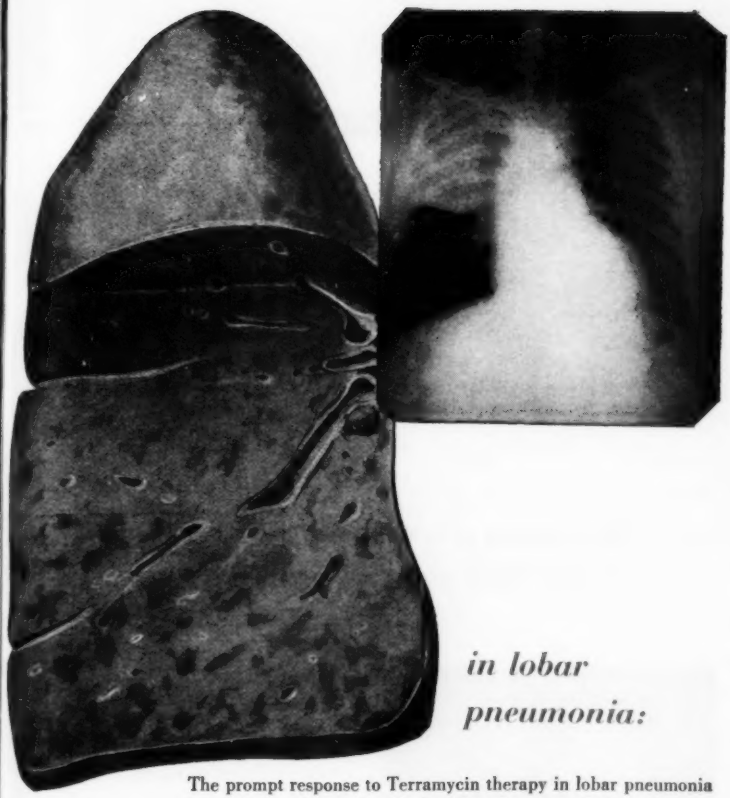

in lobar pneumonia:

The prompt response to Terramycin therapy in lobar pneumonia is consistent with results obtained in primary atypical pneumonia, bronchopneumonia and many other infections of the respiratory tract. In a typical series of pediatric cases, Terramycin-treated, "temperatures returned to normal in 24 to 48 hours after therapy was begun. The clinical appearance of marked improvement took place during the same period."

Potterfield, T. G., and Starkweather, G. A.: J. Philadelphia General Hosp. 2:6 (Jan.) 1951

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45% reduction in

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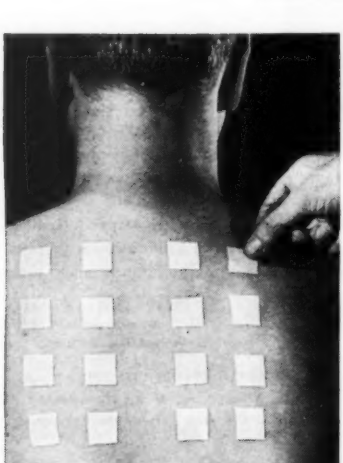
The incidence of irritation was about half that of all other leading brands in impartial clinical tests.*



There has been a rather sensational improvement in adhesive tape, and you will be interested in the story behind it.

In 1937, after many years of research aimed at reducing skin irritations caused by adhesives, the makers of *Curity* Adhesive made a major change in the composition of the adhesive mass. Contemporary tests in a well-known university's dermatology department proved Curity was the least irritating of all leading brands.

That 1937 report was encouraging, but we were not yet satisfied. Though we had reduced skin irritation to a degree not previously believed possible, we kept right

skin irritation

Curity Adhesive

on working to produce an even more satisfactory adhesive.

As a result of constant study we have now developed a new adhesive that cuts irritation just about in half. This is the largest single step ever taken in adhesive improvement.

To test the precise degree of this tremendous improvement, we commissioned a leading New York laboratory to test the new *Curity* Adhesive. Its report follows:

Proportion of individuals who react to adhesive:

	7-Day Test
New CURITY	**18.2%**
Former CURITY	**33.2%**
Brand No. 1	**38.4%**
Brand No. 2	**35.0%**

Figures include even minor erythema, not usually counted in test reports.

STICKS BETTER, TOO. Using sixteen assorted adhesive patches per individual in irritation tests, it was also noted that new *Curity* Adhesive stuck more easily and stayed on better than any other brand tested. This, then, would appear to be the best adhesive available to the profession today.

new

Curity ADHESIVE

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*Report by Killian Laboratory — summary available upon request.

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Division of The Kendall Company

designed for the

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'Eskacillin 100-Sulfas' (penicillin and the sulfonamides) has been found dramatically effective in treating many of the common bacterial infections of childhood. It is particularly indicated in the following:

Pneumonia
Acute Sinusitis
Upper Respiratory (and related) Infections

purulent rhinitis	bronchitis
nasal pharyngitis	tonsillitis
streptococcal sore throat	otitis media

Bacillary Dysentery
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'Eskacillin 100-Sulfas' is so pleasant tasting and easy to swallow that children enjoy taking whatever amount you prescribe. Each teaspoonful (5 cc.) supplies: crystalline potassium penicillin G (100,000 Units); sulfadiazine (0.167 Gm.); sulfamerazine (0.167 Gm.); sulfamethazine (0.167 Gm.). Available in 2 fl. oz. bottles.

Smith, Kline & French Laboratories, Philadelphia

'Eskacillin 100-Sulfas'

(formerly 'Eskacillin-Sulfas')

the original and outstanding FLUID penicillin-sulfonamide combination

'Eskacillin' T.M. Reg. U.S. Pat. Off.

Discharge and malodor of bacterial cervicitis and vaginitis can be markedly decreased by Furacin Vaginal Suppositories.

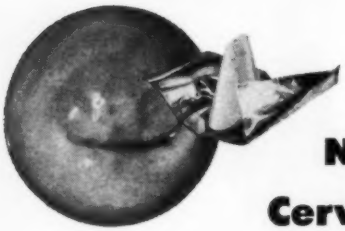
When the infection is accessible to vaginal medication, it is usually promptly eradicated by the powerful antibacterial action of Furacin, whose spectrum includes many gram-negative and gram-positive organisms.

When cauterization or conization of the cervix is indicated, use of Furacin Vaginal Suppositories pre- and post-operatively is reported to produce cleaner, faster healing with less slough and drainage.

TO DECREASE DRAINAGE

TO MINIMIZE MALODOR

TO FACILITATE HEALING



New Therapy in Cervicitis & Vaginitis

Furacin Vaginal Suppositories

Furacin® Vaginal Suppositories contain Furacin 0.2%, brand of nitrofurazone N.N.R. in a base which is self-emulsifying in vaginal fluids and which clings tenaciously to the mucosa. Each suppository is hermetically sealed in foil which is leak-proof even in hot weather. They are stable and simple to use.

These suppositories are indicated for bacterial cervicitis and vaginitis, pre- and postoperatively in cervical and vaginal surgery.

Literature on request

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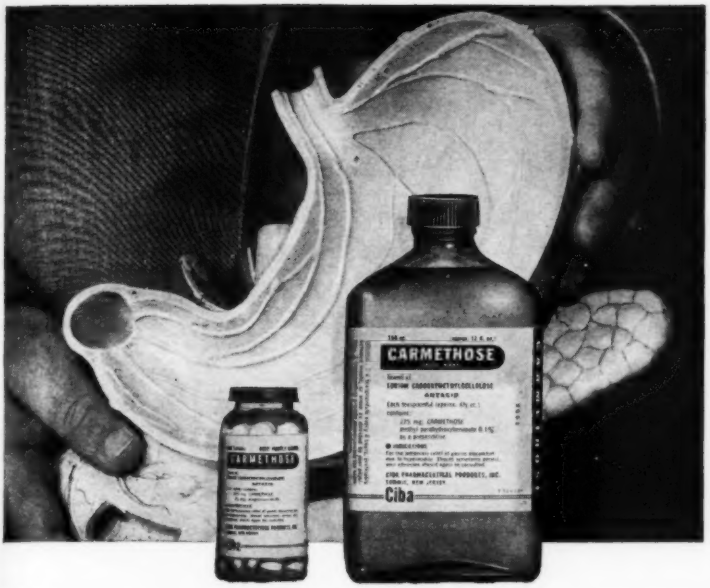
A unique class of antimicrobials



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Without Side Effects

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No Acid Rebound — Carmethose is an acid modulator, *not* a neutralizing antacid.

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No Systemic Disturbance — Carmethose is sodium carboxymethylcellulose which is non-systemic and does not interfere with digestion, absorption or acid-base balance.

DESCRIPTION—Carmethose® Liquid is a 5% aqueous solution of sodium carboxymethylcellulose; in bottles of 12 fl. oz. Carmethose Tablets contain 225 mg. of sodium carboxymethylcellulose and 75 mg. of magnesium oxide; bottles of 100.

DOSAGE—Four teaspoonfuls or four tablets on arising, between meals and before retiring. Or, if indicated, two teaspoonfuls or two tablets every two hours.

Ciba, SUMMIT, N. J.

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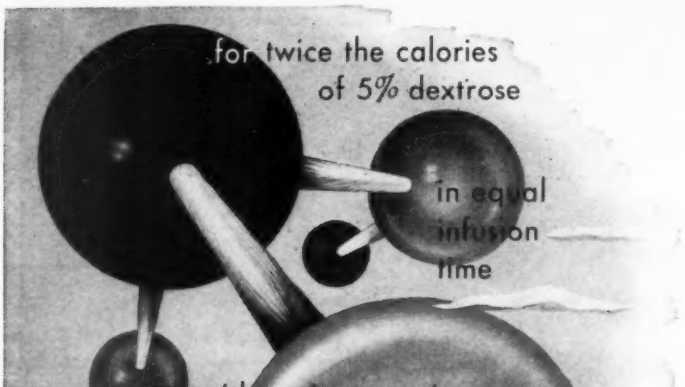

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Editorial

Are Salaries Unethical?

• "A physician should not dispose of his professional attainments or services to any hospital, corporation, or lay body . . . under terms . . . which permit the sale of [his] services... by such agency for a fee."

Take a good look at that dictum. It shows signs of becoming one of the most hotly debated in medicine. Reason: It bans an arrangement that thousands of physicians have long worked under and that now puts them beyond the ethical pale.

Who are these physicians? They are the salaried men in hospitals, medical schools, even in some medical groups. If the employing agency charges patients anything at all for their services, these doctors must presumably be tagged as unethical.

Yet the statement quoted does not appear in the Principles of Medical Ethics. It originated with an A.M.A. reference committee in June 1950, as an addendum to the Hess Report. The House of Delegates later approved it—though not without considerable dissent.

The aim, of course, was a thoroughly laudable one: to keep hospitals from profiteering on the work of their staff specialists. But the disputed dictum seems so sweeping as to raise the question of whether it doesn't generate more problems than it solves.

We believe it's time for our policy-makers to give further consideration to this matter. They might well re-examine their 1950 ruling in the light of the situation at Yale University School of Medicine, where nearly 100 well-known physicians have been declared in violation of this clause; at the Cleveland Clinic, where the entire salaried staff has heard intimations of possible medical-society expulsion; and at scores of other institutions throughout the land.

Our ethics code quite properly warns us against disposing of our services under terms that permit "exploitation." But are doctors on salary *necessarily* being exploited?

The statement quoted above seems to say "yes." So large numbers of such physicians now find themselves in an ethical dilemma, and there is open dissension between fee-for-service practitioners and their salaried brethren.

If doctors start fighting doctors as well as the hospitals, it will be a sad day for private medicine. The best preventive is new light on salaried status, emanating from the A.M.A.

—H. S. BAKETEL, M.D.

Goodbye to Group Practice!

Is group medicine all it's cracked up to be? This physician answers with a sharp, disillusioned NO

● They say you don't know a woman till long after the honeymoon. Well, it's just as true that you don't know group practice till you've been in it. I ought to know. As a salaried staffer, I tried it twice—four years in one large group, five years in another. But never again!

Today, after several years in solo practice, I can claim some perspective. My group experience made me a better physician. I learned a great deal of medicine from it.

But I learned a great deal more about medicine as an organized industry. I was offered $25,000 to stay; but I can honestly say that I wouldn't go back into group practice for $100,000 a year.

Why did I go into group practice to begin with? From the outside, it seemed a five-way dream: (a) convenient laboratory facilities; (b) easy in-group consultation with skilled colleagues; (c) freedom from economic pressure; (d) time for graduate study and research; and (e) nothing to consider except the patient's welfare.

Unfortunately, the dream didn't square with reality. It didn't even come close.

Take the matter of laboratory facilities. Because we ran off more tests, I suppose our group practice *was* better in some ways. But we did a lot more tests than were necessary, and they were very expensive for the patient. Once in a while the tests uncovered a diagnosis we hadn't learned from the history. But that doesn't reflect too well on the brand of diagnosis.

Why did we order superfluous tests? Partly to impress the referring physician; but even more to save time. It was easier and quicker than asking questions. And the more tests we could order, the less strain there was on our clinical knowledge and judgment.

There was also an economic reason for these procedures. Every department in the group was required

---

The author, now in private practice in an eastern city, is a board-certified specialist. To give him full freedom of expression, the editors have let him relate his experiences anonymously.

to show a profit. So when the X-ray department dipped into the red, a pink slip would turn up recommending that we order more X-rays. Thereafter, all hay fever patients would have routine sinus films *before* they even saw a physician.

When the laboratory reported any slack periods, one urinalysis was not enough; we did two. And we could always order a stool specimen and look for parasites. If none was found, we tried again. At one time, we were using more cardboard containers than the local Howard Johnson restaurants.

What about that second advantage—the opportunity to pool our medical experience? I quickly discovered how far off *that* dream was.

True, the surgeons called in medical men when they thought they had a medical problem, and we consulted them on surgery. But after a while, I learned to make do with a minimum of calls. We of the medical staff rarely conferred. We weren't anxious to parade our ignorance before each other. How quickly you learn to read the quizzical look that says, "You mean to say you don't know *that*?"

The big boss of our clinic always said that the ideal way to run any department was to get a brilliant, well-trained man to head it and conscientious, mediocre physicians to work with him. The department head could always pull their medicine up to his standards, the theory went. But it didn't always work out.

As to income, some less able group physicians probably did better than they would have in private practice. But as far as I know, every one of us who left the two groups has netted two or three times the annual income that group practice provided.

The fact is, the salaried group doctor *is* a wage slave. His base pay always lags well behind the cost of living. Some of us had equal salaries, but we by no means worked equally hard. Salaries, in fact, were in no way correlated with our skill, training, or living costs. They merely indicated how cheaply the big boss could get us.

Pay-Raise System

To get a raise, we had to humble ourselves and ask the big boss for it. I must admit that I was given every increase I requested. But in my own department, one physician hadn't had a raise in ten years. He was afraid to ask for fear he would be told that the group could get along without him. After fifteen years, he was still earning $6,000 annually.

True, there was a Christmas bonus for department heads and for others who had done outstanding work. So everyone worked busily in his empty office the day before Christmas, waiting for the magic summons. Perhaps his telephone would ring, and he would go to get his check, along with the usual glad talk. Otherwise, along about 4 or 5

o'clock, he would see the big boss leave in his limousine and know there was no bonus coming that year.

To me, this simply doesn't add up to "freedom from economic pressure." We were taken on for a year at a time. If we didn't please everybody all the way up, our contracts were not renewed. And that meant no office, no income, and no practice built up.

Naturally, we had to please the patients. If they didn't like the way we handled them, they could always complain to the referring M.D. He quickly communicated with the department head or the big boss. We soon got the word.

And we had to please our colleagues—to say nothing of their wives. A man couldn't stay in the group if they didn't like his religion, his politics, or the way his wife entertained.

We were actually told how to vote; and we voted as we were told. What would *you* do if a note came around telling you that if the Democrats won the local election, there would be no bonuses that year?

Ours was a closed society. It was disloyal to have outside physicians as friends. Friendliness with employes and nurses was also frowned on. One group physician who married a nurse was so effectively ostracized that he had to leave within a year.

But didn't extra time for study and research compensate for these drawbacks? Extra time? I don't remember any. Our hours were 8 to 5 or later, six days a week. We often saw patients in the evening outside the clinic building. Most of us had to return several evenings a week to catch up on dictation.

Which didn't mean that we weren't *always* available to talk before medical societies. At county society meetings, we gave out only enough information to show the local doctors how much we knew, and how necessary it was for them to send us their patients. We were the bright boys who dazzled the G.P.'s with papers on argentaffin tumors and on osteochondritis dissecans. We never told them how to keep and treat patients themselves.

At the national conventions, of course, we were disarmingly frank about our work. There we were talking to a limited group of experts who weren't in local competition. From the local groups, we wanted patients; from the national groups, we wanted headlines.

Though each of us was told to write papers as often as he could, these were presented with the utmost personal anonymity. The group, however, had a public relations tie-up. Hence any famous patient made the newspaper headlines almost before he stepped off the plane.

From every rare case, from every new medicine, the group got all possible publicity. We naturally stood for the most advanced treat-

Next Year's Model, He Hopes

ment methods, and gave the impression that they were always successful. This was "ethical advertising," and we needed lots of it. What was unethical for individual practitioners was expected of us as a group.

It is true that we never split fees or made unethical promises. We had more subtle ways of stealing patients from outside practitioners.

We were never so crass as to say, "Come to us for treatment." But it

More Than Corn Flakes

The impact of the Kellogg Foundation on rural health • By Alton S. Cole

• What has breakfast food to do with rural health? In Michigan—and a growing list of other states—plenty. For Battle Creek's W. K. Kellogg Foundation, endowed with corn-flakes millions, is outstanding among private agencies working to boost the quality of rural medicine closer to that available in cities. From limited beginnings in the Great Lakes region during the 1930's, Kellogg's activities are now branching out to other parts of the country.

Pilot venture of the organization was its Michigan Community Health Project, on which it spent $8 million up until the last war. This was confined to seven counties around Battle Creek. Within this test-tube area the foundation delved patiently to uncover the main problems of rural health betterment, then devised measures to meet them. It fostered the formation of county health departments, the construction of hospitals, and the post-graduate education of doctors, school teachers, and others concerned with public health.

But most of all it plugged for what it found to be the biggest need in rural medicine: adequate diagnostic services. "None of these communities had adequate clinical laboratory or X-ray facilities," says Graham L. Davis, director of Kellogg's Hospital Divi- [*Continued on page* 209]

was quite obvious to the patient that *we* made the diagnosis and that *we* knew all the mysteries of modern medicine. Quite often, the patient *forced* the G.P. to send him back to us. If the G.P. objected, a lifted eyebrow told the patient what we thought of a physician who was that old-fashioned.

How did the patients get along under this system? It varied a great deal. When the surgical staff was busy, we told a patient with a thyroid adenoma that we'd watch his condition—come back in three or six months. When the surgeons reported slack times, the patient was told he had a potentially cancerous condition that should be taken care of immediately.

During vacation periods, gallstone patients who were not acutely ill learned that no harm would come of waiting. But during the fall, gallstones came out pronto. Thus our policy toward elective surgery changed according to our surgeons' work-load.

We saw so many patients that we couldn't really give a damn about any individual one. Unless, of course, he had an "interesting" ailment—something that might result in a paper, bring us glory, and elevate the group politically. We had neither time nor inclination for personal patient relationships. In fact, these were frowned on; for they raised the possibility that a physician might leave the group and take some patients with him. As a result, we rarely saw any patient a second time.

But the patients were sold on the magic of the group name. I used to look in on them occasionally, as they waited (sometimes all day) to see a physician—not one of their choice, but one assigned by the office. They never knew that the office had a credit rating on each of them. Not infrequently, the patient with a poor credit report was given very short service.

There was one type of patient whose welfare we really took to heart. He was wealthy or important, and everybody from the elevator boy up knew it. He was taken through the group at a steady yet leisurely pace. Something was done for him every moment. Then he was rushed up to the big boss for a final going-over. And did he pay for it! The fee for an ambassador or a big business executive was astronomical —as much as most of us earned in two years.

When I left the clinic for good and went into solo practice, my standards of medicine automatically became higher. No longer could I depend on the lab or my chief for interpretation of diagnostic data that did not tally.

I now order such tests as I need to corroborate what I have learned, not to save my time at the patient's expense. And the patient's welfare is entirely *my* responsibility. He can't be shared or lost in the shuffle of a group. END

Beginning a step-by-step course of instruction for the physician's office

The career of medical secretary continues to gain in standing. And for good reason. The physician's office assistant is both his business manager and his public relations officer. She can make or break his practice.

The writer of these letters, after receiving her A.B. degree, was for sixteen years secretary to a well-known surgeon. When, in time, it became necessary for her to move to another city, she promised to train her successor in all the details of medical office management. Since she had time to give only brief, oral instructions before she left, it was understood that she would write regularly and often.

This she did, and her letters found their place among the younger girl's most prized possessions. With the personal items deleted, they were

Letters to a Doctor's Secretary

• My dear Mary:

How's your enthusiasm over your new job by this time? Keener than ever, I hope, because that was what tipped the scales in your favor over twenty other applicants for the position. You said you'd like to be a doctor yourself, and next to that you'd rather help a doctor than do anything else in the world. Your eyes shone with zest at the idea. Zest, that ingredient indispensable to success and happiness in your work, was one of your most valuable recommendations.

But I want you to understand that the career you have chosen is far different from one in the business world and requires a special sort of aptitude. If you find that close contact with sickness and its misfortunes is distasteful or that it causes you to feel worried or depressed, you will do much better to hie yourself to some corporation office as soon as possible. But if, as I suspect, you discover that these things bring out in you the urge to help and comfort, then you are in the right place.

office assistant

published originally as a series in MEDICAL ECONOMICS, *signed with the nom de plume Myrna Chase.*

So many requests for republication have been received that this new series is the result. All the original material has been revised and brought up to date; some new material has been added. The current series will also be made available in portfolio form.

When my mother was a girl, there were only three ways in which a "refined" lady could earn wages without supposedly losing her "refinement." These were teaching, nursing, and working in a doctor's office. The young lady of that day dabbled in the last only if she were not well educated enough or not physically strong enough to do either of the first two. She usually wore a black silk apron over a wool frock, and the work she did could have been accomplished by a 12-year-old.

That, however, was long ago. The girl who works for a doctor today enters upon a real career. She is required to take medical dictation, write case histories, keep accurate files, handle the doctor's correspondence, prepare manuscripts for publication, as well as to act as hostess, nurse, mother, telephone operator, bookkeeper, collector, treasurer, and diplomat extraordinary. But don't be alarmed! I promise to write you regularly and to discuss no more than one subject in each letter.

Are you ambitious? Dr. Barrie's office encompasses no hierarchy of positions that you may hope to win through promotion, for there is no one over you but the doctor, and his place you can never fill. But within your position itself is the possibility of infinite expansion. You

By Anna Davis Hunt

can continue to learn and improve from day to day and from year to year. You can keep pace with the career of a man who is doing the most splendid and worth-while work in the world; and by making yourself indispensable to him you may feel sincerely that you are sharing his accomplishments.

You will spend your working hours in a home-like office made inviting by flowers, pictures, and magazines—far from the clatter of commerce. The management of the entire place will be in your hands if you show yourself capable.

Do you like people? You will meet all kinds under profoundly interesting circumstances. The spice of variety will never be absent. Your mind and your heart will never lack for food.

In fact, I know of no office career for a woman that is more varied, more colorful, less given to dull routine. It reminds me of those advertisements of Southern California: "From the mountains to the sea . . . in a few hours from hot desert sunshine, to warm surf bathing, to orange groves and acres of wild flowers, to snow-covered peaks and trout fishing in icy mountain streams . . ." Your present work might be described similarly: "Only a few minutes from the tumbling surf of personalities and emotions to the cold, solitary peaks of science, mathematics, or composition . . . then back again, with many a way-stop between."

You will not, of course, enjoy the unlimited capital of big business behind you. You will probably never have a pension except Social Security. But as you increase in helpfulness to the doctor, especially as you learn to handle his collections and save money for him, your salary will grow in proportion. He is generous and appreciative. He realizes fully that even one bad account collected by your industry or one wavering patient held by your tact can compensate him for your salary increase for a year.

There are other practical benefits connected with your position. Should you fall ill, you'll have no doctor bills to pay. The dentist and oculist will probably give you a professional discount. The pharmacist will allow you the regular doctor's discount on all your personal purchases.

You'll receive kindly consideration from the bank and from all the business firms with which Dr. Barrie deals, not only for your own sweet sake but just because you are his secretary.

You've doubtless gathered by this time that I feel as much enthusiasm for your job in retrospect as you do in anticipation. I like the idea of writing you about your work. I'm still a little homesick for it myself, and I'll enjoy putting down in black and white the many details of sixteen happy years.

Cordially yours,
Myrna Chase

Get Income-Tax Credit for Your Gifts

Here are the ground rules for saving while giving. They'll pay off March 15

● You like the man's story. You really believe in the cause. Next thing, you've got your checkbook out.

"Hold on a minute," you tell the man, a neighbor from down the street. "On second thought, I'd better give you cash. I didn't get to the bank today, and I've got a lot of loose bills around."

You peel off $50. Your neighbor scribbles on a slip of paper and gives you a receipt that shows you've given to a worthy charity. You feel pretty good about it. [*Turn page*]

By Alfred J. Cronin

The author is a member of the firm of Murphy, Lanier & Quinn, public accountants.

But come the Ides of March, you may not feel so good. While scanning your income tax form, you notice that every important deduction requires proof. In order to claim a gift deduction, for instance, you must be able to prove what you gave, when, and to whom. Can you?

The slip of paper has disappeared. Your fund-collecting neighbor is on prolonged business trip to Europe. It's entirely possible, therefore, that the revenue man will give you sympathy—but no deduction.

What would qualify as proof in such a case? Surest answer: a canceled check. Whenever possible, this should be supplemented by a letter of acknowledgement from the group that received your donation.

Besides failing to have sufficient proof, many medical men learn too late that they've made contributions to groups that, deduction-wise, are not recognized by the Treasury Department.

"You may say that I favor socialized medicine."

Non-Deductible Gifts

What about donations to your medical association, for example? They are not deductible under the heading of gifts (although you can sometimes declare them as professional expenses).

What about a gift to your hospital's building fund? If it's a nonprofit institution, you can claim the deduction. But if it's a proprietary hospital, you cannot.

As a general rule, you are allowed to deduct gifts to organizations that are (1) operated exclusively for religious, charitable, scientific, literary, or educational purposes; (2) set up formally as nonprofit corporations, trusts, funds, or foundations; and (3) located in the U.S. or its possessions.

Your church, your community chest, the Red Cross and similar organizations, and some fraternal orders qualify. You may also deduct any contributions to national, state, or local governments "for exclusively public purposes."

But note that gifts given directly to private individuals or to unorganized groups are *not* deductible. Nor are contributions to a political fund, to a lobby organization, or to any group whose earnings benefit private persons.

Another thing: Your gift must be in a tangible form (*i.e.*, real property or money). Thus the value of professional services donated to a charity clinic or other welfare group cannot be deducted, even though such services are contributed in the same spirit as monetary gifts.

If you've made a gift of property, your deduction will be based on the fair market value of the property at the time of your donation. To substantiate such deductions, it is wise to get a written estimate of the property's value from a competent appraiser. Incidentally, the appraiser's fee can be deducted as an expense of preparing your tax return.

Ceiling on Deductions

And don't forget there's a ceiling on deductible gifts. You're allowed to deduct up to 15 per cent of your adjusted gross income for this purpose. Suppose, for example, that your 1951 records show the following:

Professional income (net after expenses)	$11,000
Other income (dividends, interest, etc.)	800
Adjusted gross income	$11,800
Contributions made during 1951	$ 2,100

Can you claim as a deduction the entire $2,100? No, you cannot. Your deductible gift limit is $1,770 (15 per cent of $11,800).

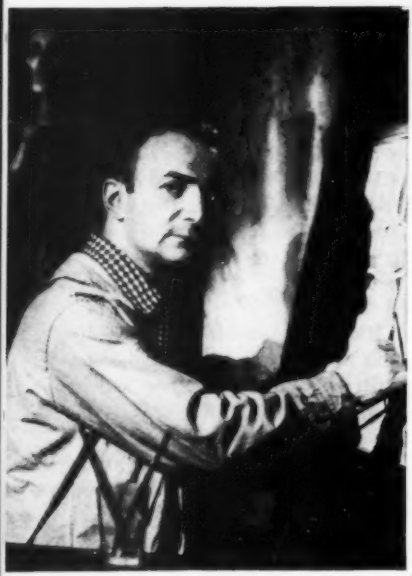
Contributions are good tax deductions only in the year paid, regardless of when pledged. If, for example, you signed a pledge this year to contribute $200 to the community chest, and you don't pay the $200 until Jan. 2, 1952, that makes the deduction apply to your return for 1952, not for 1951.

Two-Way Savings

Here's an interesting tax-saving possibility: Suppose you hold a security that cost you $1,000 and is now worth $1,500. If you want to make a charitable gift of the latter amount, give the security itself. Should you sell the security for $1,500, you'd have to pay a tax on the $500 capital gain. Contributing the security itself costs you nothing in tax, gives you a charitable deduction of $1,500, and furnishes the charity with the full $1,500 worth.

On the other hand, if a security cost you $1,000 and has declined in value to $750, reverse the process. Sell the security and contribute the $750 cash proceeds to the charity. That gives you not only the gift deduction of $750 but also a capital loss deduction of $250.

Whatever form your gift takes, you'll do well to ask yourself these three questions each time you make a donation: (1) Do I have sufficient proof of the gift? (2) Is the organization recognized under the tax law? (3) How do I stand in relation to the 15 per cent limit? END



Frank H. Netter, M.D.
In a class by himself

Mary Lorenc
To M.D.'s: Brief your artist

Coral Nerelle
Doctors lobbied for her

Art for the Doctor's Sake

You've profited from their medical drawings. But who are these little-known artists? And how do they work?

● Though generally unsung—and often unsigned—the work of the medical illustrators is rarely out of an M.D.'s sight. It aids and abets him from medical school through a lifetime of learning to the day when he uses it to help immortalize himself in a textbook, a lecture, or a clinical paper.

The medical artist has by no means been displaced by photography (that "valuable record of the obvious," as the late Max Broedel called it). Instead, the demand for top-flight illustrators today is greater than the supply—twice as great, say some medical educators.

Even Congress has recognized the artist's value to the medical profession. Under pressure from an informal medical lobby, the House and Senate recently granted permanent U.S. residence to Australian-born artist Coral Nerelle. Miss Nerelle came here five years ago on a temporary student visa to study medical art at Johns Hopkins; she's now staff artist at the Veterans Administration Hospital, Richmond, Va.

Who are these much-wanted medical illus-

By James Fuller

Medical artists sometimes come in unique pairs. Not only are Brooklyn-born Florence and Ruth Lee identical twins; they're both married to ophthalmologists they met in line of duty. The twins' artistic specialties: abdominal and brain surgery—and eye work. It was while teaching art in a V.A. hospital that the Lee sisters broke into medical illustrating together.

trators? They are artists first, science specialists second. Of the 200 or so professionals in the U.S., only one is an M.D.; but most of the others are old hands at anatomy, histology, embryology.

These people do their stuff in medical schools, in research labs, in hospitals, and occasionally in doctors' offices. Some are full-time staffers, some part-time; others are free lances. Judging from the latest directory of the Association of Medical Illustrators,* there are five women in this field for every four men.

Why this preponderance of females? "Not being bothered by the creative urge," says one male illustrator, "women are better at recording details. They aren't tempted to embroider for art's sake."

"Nonsense!" retorts a female artist. "It's just that the work takes great patience—a virtue of women. Then too, except for the commercially successful few, medical art pays rather meagerly. Maybe only a woman can live on it."

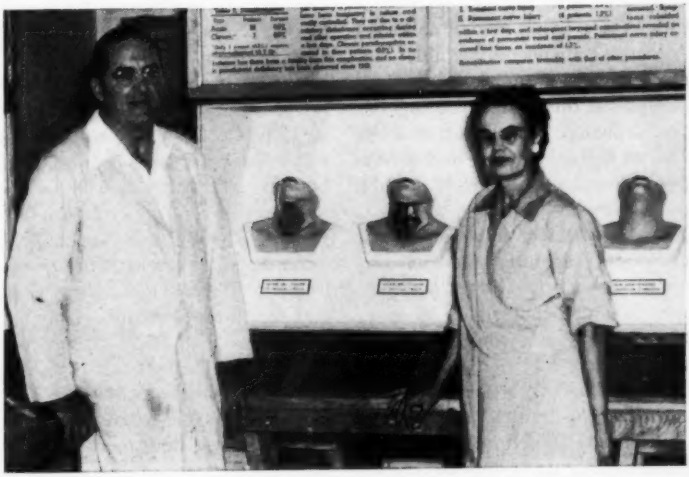
The best medical art is the joint product of the artist *and* the doctor. Yet "surprisingly few M.D.'s know how to work well with an artist," says one leading illustrator.

How *should* a doctor collaborate with his artist? Here's an example given by Mary Lorenc, staff artist for nearly twenty years in the anatomy department of New York University-Bellevue Medical Center. Her assignment on this occasion: to illustrate surgery on the peripheral nerve system for a new textbook.

You can't sketch these procedures in the operating room alone, Miss Lorenc points out: "The movements are too rapid; hands, instruments, and spot lamps are always in your

*Out of print for the time being. However, physicians who want to find competent illustrators in their vicinity should write to the secretary of the Association of Medical Illustrators, Miss Mildred Codding, Peter Bent Brigham Hospital, Boston 15, Mass.

Tom Jones: ***Once commissioned to paint an inside portrait for nobility***



Kenneth and Margaret Phillips: ***For medical meetings, sculptured surgery***

line of sight—even if you stand on a stool, as I often do." Her solution in this case was to get her doctor-collaborators to start her further back:

"First, the anatomist dissected a cadaver for me, giving wide exposure around the operating field. This gave me a good close-up of all structures to be excised and incised. After drawing all this, I then watched the actual operations, making notes on the color and appearance of living tissue (so different from dead tissue), on instrument positions, and such.

"Next, the surgeon repeated his operation for me on a cadaver. There I got down his key actions, as well as the form and depth of the structures he actually exposed."

Finally, Miss Lorenc took photographs of a living model; collected X-rays of patients on the table; and studied surgical movies for minor details—all this before starting her final drawings. The upshot: sketches true to living anatomy, and a textbook illustrated effectively from a surgeon's-eye view.

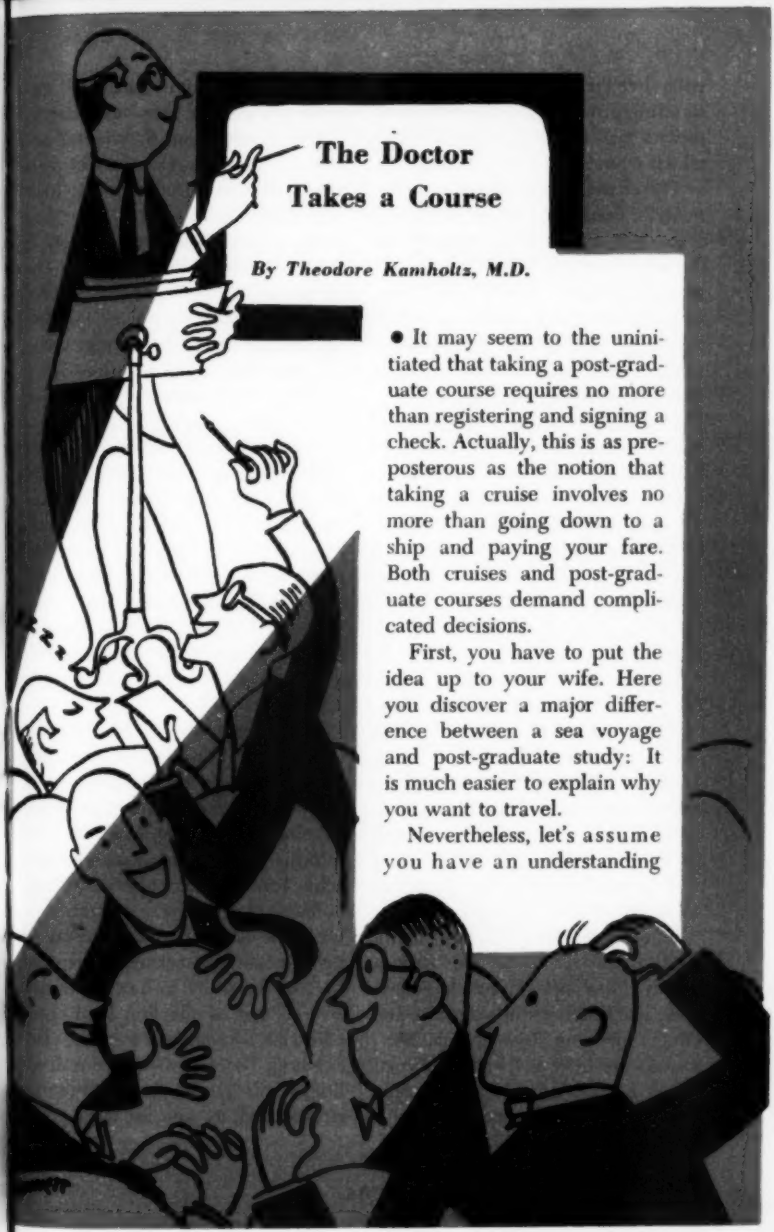
Not all medical art requires such elaborate preparation. But without a thoroughly briefed artist, you may get drawings that show no more than a photograph would show. And that's bad.

"Too many doctors are impressed —or taken in—by drawings that are 'so natural-looking,' " says Miss Lorenc. "For them, the artist's skill is wasted. They might as well use a camera, which exposes only what anybody can see. They don't get the emphasis and interpretation that really good drawings convey."

All of which indicates that Mary Lorenc is a perfectionist—a virtue that unexpectedly launched her on her medical career. A native New Yorker, she was studying at the Art Students League when she got the feeling that the surface anatomy taught there was "pretty silly." To get the inside stuff, she joined an anatomy class at N.Y.U. medical school, dissected everything in sight. Then she went on to take embryology and comparative anatomy. She's been at N.Y.U. ever since, ensconced in a tiny studio just off the anatomy lab.

Like many a medical artist on days off, she is a Sunday landscape painter. She also experiments in abstract medical art. When she freelances, it's not only for medical publications but for lay magazines such as Life. Occasionally she does an odd job for a pharmaceutical firm, but doesn't like it as well as her staff work. Her reason: "I'm not working directly with doctors."

An N.Y.U. alumnus whose work is in great demand by drug firms and the profession alike is Frank H. Netter, solo M.D. among top-rung medical artists. As physician and artist rolled into one, Dr. Netter can work independently, has more artistic leeway than most lay illustrators. "I can analyze and plan every [*Continued on page* 187]



The Doctor Takes a Course

By Theodore Kamholtz, M.D.

● It may seem to the uninitiated that taking a post-graduate course requires no more than registering and signing a check. Actually, this is as preposterous as the notion that taking a cruise involves no more than going down to a ship and paying your fare. Both cruises and post-graduate courses demand complicated decisions.

First, you have to put the idea up to your wife. Here you discover a major difference between a sea voyage and post-graduate study: It is much easier to explain why you want to travel.

Nevertheless, let's assume you have an understanding

wife (even if the price of her understanding proves to be several sets of theater tickets). You now decide which course you'd like to take.

The cruise analogy is again pertinent. In one case, you get a myriad of folders from a travel agency; in the other, several booklets from regional schools and hospitals. Tropical palms! *Newer aspects of endocrinology!* Luxurious accommodations! *Two clinics a week!* Quaint customs! *Visiting professors!*

You skim, read, then study these enticing and deceitful brochures. You balance time and value, drawbacks and advantages. You winnow the field down from twenty courses to two, then you decide that, more than anything else, you want to take the course entitled, "The Physiological, Pathological, and Psychosomatic Aspects of Backache."

Four weeks, nine hours a week. Six hours of didactic lectures. One hour in round-table conference. One hour of clinic work. One hour in the laboratory. Slides. Anatomical demonstration. X-rays. The newest concepts of low back disease presented by the combined staffs of hospital and medical school. Guest lecturers Mon., Wed., Fri., 5-7 P.M.

Monday 5 P.M. finds you in the hospital auditorium. You have a freshly filled pen in hand, a new loose-leaf notebook on your lap, and hunger gnawing at your vitals. Most courses are held at the time normal people eat or busy practitioners hold office hours. There seems to be a delicate assumption that P.G. students are neither busy nor hungry.

You glance about the auditorium. Down below you, two doctors seem more interested in reviewing their experiences, jokes, and miseries than in the course. Another physician is composing himself for what is undoubtedly a well-earned nap. An eager beaver is seated in the first row so that he can better take notes, ask questions, and be noticed. Five doctors, in all, have turned out for the course.

This is the point where you have your first misgivings. Out of pique, the sponsors of the course may cancel it. Or, by way of keeping up appearances, they may combine your group with the one that signed up for "The Psychodynamics of Avian Malaria." Luckily, however, the staff merely acknowledges the small attendance gloomily and the course is officially begun.

Lecture No. 1 is an elaboration of the syllabus. The lecturer presents the perspective of the problem in the world of today—a sort of "Backache and the Soviet Situation." He informs you that there are 1½ backaches for every 2 people. The place of backache in the evolution of medicine is given: what Leeuwenhoek meant to backache and what backache meant to Leeuwenhoek. By the end of the first hour, your notebook is crammed with the stark heading, "Lecture One," plus doodlings. Still in all, your enthusiasm runs as high as your art work.

While you're getting your intermission smoke, you mingle with the other students and congratulate yourselves on this fortunate choice of course. That is, all except Eager Beaver. He's hounding the lecturer about Herodotus and *his* backache.

At the beginning of the second hour's lecture, the speaker coyly invites everyone to come down front. The back of the auditorium is then vacated, except for the somnolent one settled down near the rear exit.

Kindergarten Stuff

This lecture is listed simply as "Basic Anatomical, Physiological, and Psychological Aspects of the Back." The lecturer concedes that there are vertebrae, muscles, nerves, ligaments, and attitudes; further, that sometimes something may go wrong with a vertebra, muscle, nerve, ligament, or attitude. This is done in a manner that anyone can readily understand—and does, without benefit of lecturer. Your doodling is interrupted only by reflections on what you'll tell your wife when she asks what you got out of the course.

Wednesday 5 P.M. finds you in the rear of the auditorium near the exit, sans notebook or pen. Then ensues a lecture about the radius of inclination of the apophyseal articulations in primitive amphibians. This fascinating talk is delivered in a low monotone to a large sheaf of notes lying on the lectern. It is provocatively illustrated with misplaced slides, faded X-rays, and labored chalk drawings for which the lecturer is endlessly apologetic.

At the intermission, you and your fellow students smoke in awkward silence—again except for Eager Beaver, who is harassing the lecturer about the sacroiliac joint in newts.

The second hour's lecture is a clinical one—something to do with inability to swallow. Capistrano's disease, you think he called it. Anyway, it's a rare disorder, with only two cases reported in the literature—even though the lecturer tells of five such cases he has seen in the past week. With ten minutes left, he lists all other diseases of the back, stating alternately that he doesn't want to exceed his time and that he will go into them later.

The fact is, that in many postgraduate courses, either the disease is terribly esoteric or there is insufficient time to discuss it. The implication is that the average M.D. is totally unable to treat the diseases anyway and should therefore refer any such patients to the lecturer.

At the Friday clinic, you're invited to take a patient's history in the light of your newly acquired insight. This allows the nurse to take a day off. Afterwards, the professor comes around and listens to your history. He advises X-rays, blood counts, gynecological, urological, medical, and proctological consultations. He then concludes that "we" will see the patient again next week.

In the laboratory, you're given a

whole-hearted welcome. You're invited to visit the operating room, morgue, X-ray department, library, and solarium. If you care to waste any time, you may even look at histological slides of Capistrano's disease.

The end of the first week forces you to the conclusion that, although there has been nothing gained so far, there also has been nothing lost. But if the first is the week of promise, week two is the week of tribulation.

One lecture is canceled because Professor A thought Professor B was giving it, and vice versa. Then Dr. Kalbfleish of Heidelberg, the great back specialist, is called away for an emergency tonsillectomy. The assistant pediatrics resident talks on the mechanistic basis of asynclitism.

The hospital's director of back diseases next delivers a fine lecture, entirely without notes, on his fishing trip to Maine. There is lively audience response, with you-know-who asking about the comparative merits of a silver spinner versus a scarlet button.

Friday you go to the clinic in a driving rain to find that—of course—no sensible patient has showed up. But you have an exciting game of bridge over in Internes' Quarters while your clothes dry out.

The third week is give and take. Monday you stay in bed with a good mystery, plus a hot toddy for your cold. Later you hear that the lecture you missed was worth the price of the whole course.

Wednesday's first lecture is devoted to the psychiatric aspects of backache, chiefly in unhappily married women. It is very funny, but not funny enough to relay to your wife—especially since this week *she* has a backache from lifting the kid. The second lecture that day has its points, too, with Professor A having to give his lecture backwards because his slides got reversed.

At Friday's clinic, it's discovered that while your patient has had X-rays and blood studies, he's lacking a couple of the assorted consultations that were advised. It's obviously ridiculous to discuss a patient who is not completely worked up; so you're allowed, instead, to strap the porter's back—under supervision.

The last week is spent in review and retrospect. Names and diseases mentioned briefly before are recited even more quickly this time. Credit is given where credit is due. Thanks and gratitude are extended. Of course, no examinations will be given, but those who want credit for the course will have gold engraved certificates mailed to them. From Friday's final clinic, you simply play hookey.

It's difficult to explain the reasons for taking a post-graduate course. Yet, sooner or later, the pain of one course passes away and you find yourself reading a brochure about another. Once again, you're registered.

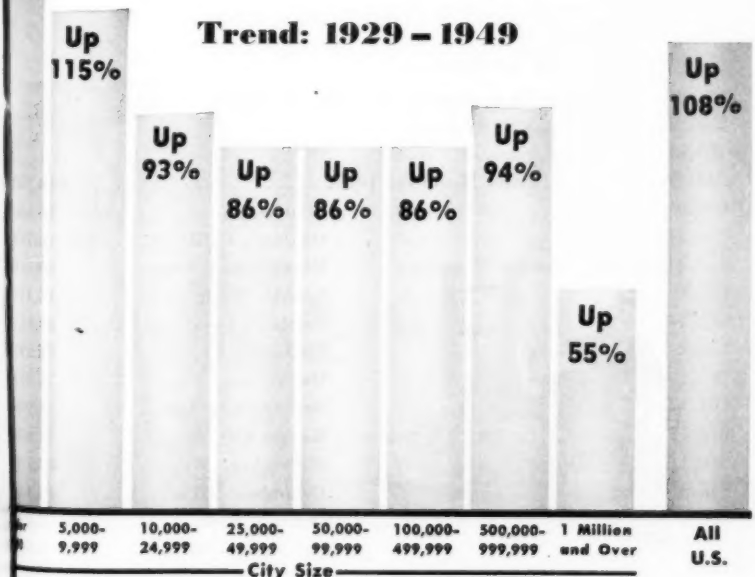
Now, dear, about that cruise . . .

END

Physicians' Incomes: by City Size

• Financially speaking, the best place for physicians in private practice is a city of 250,000 to 500,000 population. These doctors net, on the average, $1,000 more than practitioners in any other size community; their income is twice that of M.D.'s in rural areas (population under 1,000). ¶ Since 1929, however, small-town physicians have made impressive strides: They've boosted their net incomes at three times the rate reported by doctors in cities of over a million.

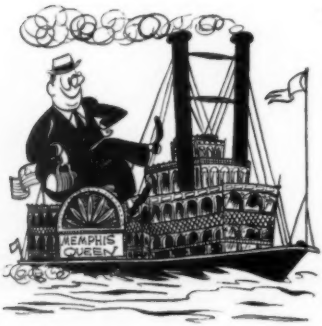
Charts are based on average net incomes of independent physicians



Small Town to Large

Pop. Under 1,000	1,000-2,499	2,500-4,999	5,000-9,999	10,000-24,999	,000- ,999

In Largest U. S. Cities



From Memphis, Tenn.	$18,75
Atlanta, Ga.	16,60
Oakland, Calif.	16,14
Minneapolis, Minn.	16,01
Seattle, Wash.	15,41
Portland, Ore.	15,31
Louisville, Ky.	15,29
Dallas, Tex.	15,24
San Antonio, Tex.	14,90
Kansas City, Mo.	14,45
Milwaukee, Wis.	14,17
Columbus, Ohio	14,16
Detroit, Mich.	14,05
Baltimore, Md.	14,03

Source: Commerce Department survey of incomes in 1949. Charts ©Medical Economics, Inc.

50,000-99,999	100,000-249,999	250,000-499,999	500,000-999,999	1 Million and Over

San Francisco, Calif.	13,917
Los Angeles, Calif.	13,773
Pittsburgh, Pa.	13,522
New Orleans, La.	13,407
St. Louis, Mo.	13,163
Buffalo, N.Y.	13,162
Washington, D.C.	12,869
Cincinnati, Ohio	12,754
Houston, Tex.	12,717
Cleveland, Ohio	12,696
Indianapolis, Ind.	12,662
Denver, Colo.	11,757
Chicago, Ill.	11,707
Boston, Mass.	11,219
Rochester, N.Y.	11,030
Philadelphia, Pa.	10,540
Newark, N.J.	9,974
to New York, N.Y.	9,237

Philanthropy in Medical Research

How the foundations and the voluntary health agencies aid research-minded M.D.'s

● When the Kinsey report on "Sexual Behavior in the Human Male" appeared in 1948, it carried this modest acknowledgment: "The Rockefeller Foundation has contributed a major portion of the cost."

This Rockefeller grant, though off the beaten track, was more typical than you might suppose. Many a foundation today considers its principal function the support of unfashionable or unpopular areas of research.

Medical research itself was unpopular before private-fortune foundations first came to its aid. Today, when Government, industry, philanthropy, and the professions are all giving generously to medical research, the special role of the foundation remains that of the pioneer.

This is a stated policy. "A foundation must act boldly and creatively at the frontiers of knowledge," declares Dr. Willard Rappleye, who is (among other things) president of the Josiah Macy Jr. Foundation. Likewise, the Commonwealth Fund reports that last year it aided forty-one medical investigations "of the type relatively unlikely to attract public attention and thus in greater need of foundation support."

Dollarwise, philanthropy's contribution to medical research is small potatoes compared to what Government and industry are now tossing into the pot.* This may surprise physicians who remember not so far back when foundations appeared to be the only significant source of medical research money.

For one long generation (roughly, from 1910 to 1940) this held true. But while private-fortune foundations today hand out only 6 to 8

*See "Who Pays for Medical Research?" July MEDICAL ECONOMICS.

By Justus J. Schifferes, Ph.D.

The author is an experienced writer and researcher in the health field. A former faculty member at Columbia University, he has also served as managing editor of three different medical journals. His articles have appeared in such magazines as Look, Scientific Monthly, and Today's Health. He has written five books and co-edited (with Dr. F. R. Moulton) "The Autobiography of Science."

per cent of the $180 million annually going into U.S. medical research, their influence runs far ahead of their dollars.

Today there are several thousand foundations in the U.S. Among the largest of them, the following ten are known to give money to make medical research possible:

¶ The Rockefeller Foundation, established in 1913. Capital assets: $158 million.

¶ The Cullen Foundation, established in 1947 and limited to Texas. Capital assets: $150 million.

¶ The Commonwealth Fund, established in 1918 by Mrs. Stephen V. Harkness and Edward S. Harkness. Capital assets: $80 million.

¶ The W. K. Kellogg Foundation, established in 1930. Capital assets: $49 million.

¶ The Mayo Association, established in 1919 by Drs. William J. and Charles H. Mayo. Capital assets: $31 million.

¶ The A. W. Mellon Educational and Charitable Trust, established in 1930 and now limited to Pittsburgh. Capital assets: $30 million.

¶ The Alfred P. Sloan Foundation, established in 1934. Capital assets: $28 million.

¶ The M. D. Anderson Founda-

What Some Voluntary Health Agencies Give Annually to Medical Research

Name of Organization	Contribution* In Dollars	Contribution* As Per Cent Of Funds Raised
American Cancer Society	$3,900,000	26%
National Foundation for Infantile Paralysis	2,300,000	9
American Heart Association	1,200,000	25
National Tuberculosis Association	400,000	2
Arthritis and Rheumatism Foundation	200,000	20
National Association for Mental Hygiene	125,000	20
National Multiple Sclerosis Society	76,000	42

*Figures given are for latest completely recorded fiscal or calendar year.

tion, established in 1936. Principal interest, Texas. Capital assets: $21 million.

¶ The John and Mary R. Markle Foundation, established in 1927. Capital assets: $16 million.

¶ The Association for the Aid of Crippled Children, established in 1900 and making grants since 1949. Capital assets: $13 million.

Until late in the 1930's these big-money foundations remained the principal benefactors of medical research. Then, a horde of little givers stepped in.

The "March of Dimes" for polio, beginning about 1938, opened new avenues of popular support. Voluntary health associations, old and new, suddenly realized that research was their baby too.

Within the past decade, these voluntary agencies have become important contributors to medical research. This year they will provide close to $10 million. That's almost equal to the amount private foundations are now able to give.

There seem to be definite limitations, however, on the amounts of research money that public appeals can raise. A large proportion of the funds collected by voluntary agencies must remain with local chapters for patient care and public education. Says one man in the field:

"Too many of our contributors are uninterested in research. They are asking, 'What about the fellow next door? What can we do for him right now?' They don't see any purpose in forwarding money to the national office for the support of research programs."

Many doctors, too, are beginning to express doubts about the incessant drum-beating of the voluntary health associations. "What—another drive! There are too many of them already," you can hear certain colleagues groan.

"Eliminate the pernicious multiplicity of drives," urges one prominent medical man. "Concentrate on a single drive, like the Community Chest." And in some places, that's already being tried.

But the agencies dedicated to the control of specific diseases have some practical reasons for maintaining their individual campaigns. They cite, for example, the educational value. A person who has contributed to a cancer fund is often more receptive to information stressing the danger signals of cancer.

Another reason why the voluntary health agencies want to maintain their separate identities is a political one. The present set-up permits them to put pressure on Congress for research grants in the areas of their specific interests.

The American Heart Association, for example, takes credit for helping to establish the National Heart Institute, which this year will lay out $7 million in Federal funds for heart research. That's about six times as much as the association itself can give.

And just last year, several vol-

untary health agencies pushed through a new Institute on Neurological Diseases and Blindness within the Public Health Service. Dr. Cornelius Traeger, medical director of the National Multiple Sclerosis Society, publicly concedes his agency's "long and active interest in the passage of this legislation."

This needling and wheedling for Federal research money is a major activity of many voluntary health agencies today. What keeps it from bringing on Federal domination is the continued support of medical research provided by these same agencies—and by the pioneering foundations. END

'Will Rogers of Medicine'

• The toastmaster finished his introduction and the big, bushy-browed man beside him got to his feet. He looked around with a slow, infectious grin. "Now I'd be right flattered to be here," he drawled, "except I've been a program chairman myself and know how hard it is to get a speaker."

An old one, but from Dr. Tate Miller of Dallas, audiences eat it up. Humanist, humorist, after-dinner speaker extraordinary, he's been dubbed "the Will Rogers of Texas medicine."

Colleagues like to tell about the time when, as professor of gastroenterology at Baylor University medical school, he turned up at a final exam with a sack of apples for the class. In a refreshing twist on an old routine,

he passed them out with the exam questions, then settled back with a big, shiny one himself. Students grinned and tension evaporated, to the tune of scrawling pencils and contented munching.

A past president of the State Medical Association of Texas, Tate Miller at 58 remains the same bluff, easy-going sort as always, ever ready with one of the knock-'em-in-the-aisles yarns that are his personal stock in trade. Yet he's never been known to shy away from a scrap.

For years he's battled for better recognition of Negro M.D.'s by organized medicine. And though a certified internist himself, he considers the certification system "mostly egotistical bunk that will pass in a few years." It's the G.P., he maintains vigorously, who is the profession's best hope for regaining the place it once held in people's hearts.

Another subject he likes to tee off on is food fads and fallacies. Some years ago he all but blew his top over a popular book listing some 300 allegedly dangerous food combinations. Seafood and milk, for instance. He devoted nearly a year to debunking the volume, lunching day after day on one or another of the "poisonous combinations" until he'd eaten his way through the whole nonsensical thesis.

The doctor relaxes in the same bull-moose manner in which he does everything else. "He's an ardent gardener," says a friend, "till he finds four worms. Then he's a fisherman." His car is usually littered with the mementos of his many interests—shotgun shells, fishing lures, okra pods, garden tools, fertilizer bags, and dog hair. He customarily enters home or office to the accompaniment of his own uninhibited voice, raised in song.

But he has a serious, scientific side that has brought him wide professional recognition; he's a frequent author and lecturer on diseases of the stomach and intestines.

His medical philosophy? It embodies his high regard for old-fashioned, family-doctor medicine—the kind his father used to practice, the kind he thinks the profession needs more of today.

"On a lot of patients," he says, "we can't make a correct diagnosis. Some we can diagnose and can't cure. But there's never a time in the practice of medicine when you can't be kind to a sick man." END

The Hospital People Hit Back

Here's what they think about salaried staff physicians, corporate practice, and the much-debated Hess Report

The physician who wrote "Medicine's Problem Child—the Hospital" (August MEDICAL ECONOMICS*) said: "The greatest single factor in restoring harmony between doctors and hospitals would be for the hospitals to withdraw from the practice of medicine."*

Most letters from readers of that article were in hearty agreement.

By Robert M. Cunningham Jr.

But some asked, in effect: "What do the hospitals have to say about all this?"

To find out, the editors invited an article from The Modern Hospital's able editor, Robert M. Cunningham Jr. You may not agree with him; but what he says is worth reading as an accurate reflection of current hospital thinking.

• Punchy from in-fighting over the Hess Report and from the year-long wrestle for control of hospital standardization, hospital and medical leaders in recent months have been exchanging syrupy generalities about the need for better understanding. "Doctors and hospitals are interdependent," A.M.A. president John W. Cline declared recently, calling for an end to the controversy. "The true values of the hospital to the public must not be endangered by misunderstanding," A.H.A. president Charles Wilinsky echoed soothingly, agreeing to the need on both sides for vision and leadership.

Listening to this kind of talk, a New York hospital administrator threw back a question with a sharp cutting edge. "When they get through throwing cotton balls," he asked, "what are they going to *do* about it?"

This particular administrator had reason to be impatient of fine talk. After weeks of negotiation, his hospital's anesthesiologist had walked out, refusing to consider any arrangement short of separate fee-for-service privileges. "He was getting a whopping big salary for a young man, too—twice what I make," the administrator added. The hospital wouldn't have had any particular objection to a fee-for-service arrangement in this case—

except for the fact that the radiologist and the pathologist were standing by, ready to demand the same concessions made to the anesthesiologist.

How Many Bills?

"They're looking right down our throats," the administrator said worriedly. "Either we stand pat, or we let patients in our town get showered with doctors' bills every time they go to the hospital."

Like most hospital people, this man believes it would be disastrous for sickness bills to get any more complicated than they are. Multiple bills from hospital specialists, this view goes, would virtually invite the Government to take over. Instead, it is felt, the voluntary system must defend and strengthen itself by working toward *integration* of hospital and medical bills.

"As a patient and as a trustee, I long for that sunshine day when doctors and hospitals find a way to bill the patient only once," the president of a hospital board said wistfully at a meeting not long ago.

The sunshine day isn't in sight; but it isn't likely either that hospital patients will soon be hip-deep in doctors' bills, as some observers have gloomily predicted. Specialist pressure has resulted in capitulation to the fee-for-service demand in some hospitals—mostly those in rural areas and smaller cities. But few such concessions have been made in the big-city teaching centers where professional habits are formed.

So far, adjustments in hospital-specialist arrangements have mostly been shifts from salary to percentage deals, with neither side scoring any particular gains—except in the comparatively few cases where specialists were underpaid or where patients were getting gouged. Everybody concedes that these cases needed fixing.

The Specialists Balk

Especially in medical centers like Boston, New York, Philadelphia, and Chicago, administrators have reported that many specialists don't want fee-for-service. They are well paid, for the most part, and they would rather let the hospital's business office worry about billing, collecting, and record-keeping.

"Until three or four years ago, our anesthetists were on a fee basis and rendered separate bills," Leslie Reid, administrator of Chicago's Presbyterian Hospital, told a group of hospital people some weeks back. "They gave free care to clinic patients, but [otherwise] were privileged to render bills on a private basis and collect their own fees. But because of the difficulties of rendering bills and making collections (and because of the difficulties involved in the problem of who gets the better patient in order to get the larger fee) . . . the department . . . suggested we put all the anesthetists on a salary basis, have the

hospital collect the fee, and simply pay them for their services. That relieved them of a great deal of bookkeeping and collection routine. It took them out of the business side."

Medical Veto

The situation at Presbyterian isn't unique, but it isn't typical either. At another large city hospital recently, the anesthesia staff was pressing hard for a switch from salary-and-commission to fee-for-service. The executive committee of the medical staff backed up the anesthetists. But when the matter was debated at a meeting of the entire staff, that group voted overwhelmingly in favor of the existing arrangement.

"Once the anesthetists switched over, the rest of the specialties would quickly follow, and the roof would fall in on our patients," explains a surgeon who actively opposed the change.

That kind of remark hurts the occupational pride of radiologists, pathologists, and anesthetists, who are constantly comparing themselves professionally to surgeons and obstetricians. "If they do it, why shouldn't we?" the hospital specialists ask, referring to individual fee-for-service billing.

Hospital people have an answer for that one. "Monopoly," they say. The surgeon and obstetrician must compete with their colleagues for patients, they point out, whereas the "inside" or hospital specialist has his patients handed to him like the hat-check concession at a night-club—a circumstance with an obvious economic advantage.

How much is such an advantage worth? Should the pathologist's freedom from competition make him content to earn less than the surgeon? Is the hospital entitled to a profit on medical services, in return for the monopoly it hands over to its specialists? These are the practical questions that individual doctors and hospitals must argue to individual conclusions. These are also questions for negotiation in the high level A.M.A.-A.H.A. conferences that both sides hope may usher in a rosy new era of hospital-medical relations.

The Big Question

Actually, the rosy new era will start the moment both sides can agree on the answer to a single, simple question: *Is it right or wrong for a hospital to earn a surplus on medical service?*

Stripped of its intricate verbiage, the Hess Report says it is wrong. Hospital people say it is not only right but economically necessary today to cover deficits developed in other departments. Both groups claim the law is on their side.

Outside the specialties concerned, most doctors probably wouldn't care much about it, except for a feeling that some important legal or ethical principle is at stake. [*Turn page*]

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The practicing physician abhors "corporate practice" as he abhors Communism. If that's what this is all about, as he is often told, he's against it. The practicing physician also wants to be ethical. If this is an ethical matter (and he is often told it is that too), he's on the side of the angels—the A.M.A. angels, that is.

Whether there is actually any legal or ethical principle involved is a matter of opinion rather than fact. Legal authorities have looked both ways on the corporate practice issue, but the courts can scarcely outlaw all salaries for doctors. Beyond that point, the question of whether a hospital (or medical school, or clinic, or insurance company, or industrial firm) is making a profit on medical service is more an accounting than a legal matter.

It's also debatable whether physicians working for hospitals, clinics, and medical schools are unethical. The A.M.A. Principles of Medical Ethics make contract practice unethical only "if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered." The Hess Report goes further, however, and raises a doubt about ethics in *every* case where the contracting agency collects more than it pays the physician.

This ethical hairsplitting gives hospitals a pain in the board-room. "It is a pretty poor kind of ethics that thrives only in terms of dollars and cents received," Robert Cutler, president of Peter Bent Brigham Hosptial in Boston, declared at the recent A.H.A. convention. "The high plateau of professional living is one where enthusiasm for the enterprise (and one's associates in it) transcends and minimizes the financial aspects."

Dr. Wilinsky drove the point home: "Ethics has always been a moral issue," he said. "Some would now have it become an economic one."

If it weren't for one thing, the Hess Report could probably be filed away and forgotten—to be invoked occasionally by a radiologist seeking a better deal, or attacked occasionally by a hospital having specialist trouble. That one thing is this: It has become more a symbol than an issue—a Holy Grail worth more in the winning than the having.

In Cleveland, for example, specialist groups have forced the issue to a point where the Academy of Medicine's judicial council must now consider whether the entire staff of the famed Cleveland Clinic, all on salaries, should be expelled from the academy as unethical—a result that nobody, including those who instigated the case, can really desire in good conscience. Besides the injury that would be done to competent, conscientious physi-

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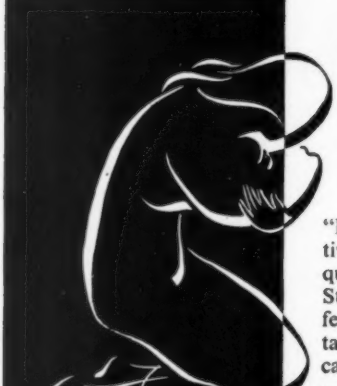

Nutritional Deficiencies Pave the Way for "Reproductive Failure"

"It is obvious to anyone . . . that reproductive failure can result from quantitative and qualitative deficiencies of the mother's diet Sterility, resorption or abortion of the fetus, stillbirth, prematurity, prolonged gestation and weakness of the offspring can be caused by dietary nutritional deficiencies."

Warkany, J.: Experimental Studies on Nutrition in Pregnancy, Obst., & Gynec. Sur., Oct. 1948, p. 693.

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Thiamine Hydrochloride	2 mg.	Manganese	0.33 mg.
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Pyridoxine Hydrochloride	0.5 mg.	Molybdenum	0.07 mg.
Ascorbic Acid	37.5 mg.	Potassium	1.7 mg.
Niacinamide	20.0 mg.	Zinc	0.4 mg.

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cians, the resulting public uproar would hurt the medical profession the way the Black Sox scandal hurt baseball.

It is persistently rumored that the A.M.A. House of Delegates may modify the Hess Report at its forthcoming Los Angeles session, and it is no secret that some A.M.A. officers think the whole episode has been a ghastly mistake. But it is by no means certain that the delegates will do anything of the kind. Many delegates see the Hess Report as an opportunity to hold dreaded "hospital domination" at arm's length. They might vote to uphold it without analyzing fully what has happened in the specialties concerned.

Whether or not the Hess Report is modified, hospital trustees and administrators are not likely to change their position. "The place of the full-time physician in the hospital has been firmly established," Dr. Wilinsky said recently. "Many individuals of high ethical ideals can find no reason for deviation from the established method of payment for full-time specialist employment."

That is the line on which hospitals are standing. So most of the vision and leadership may have to be exerted on the medical side of the line—to get rank-and-file doctors (largely fee-for-service practitioners) to accept their hospital-salaried colleagues as professional and social equals.

Thoughtful hospital and medical leaders alike see the chief hazard in full-time medicine: the possibility that an unenlightened management or an economic squeeze might compel drastic cuts in expenditures and affect the quality of professional work. For the most part, however, hospital board members don't accept this as an argument against *all* salaried medicine. Most of them have lived through depressions.

Whatever its faults, the average hospital is not likely to become a bureaucracy. The average doctor has more to gain by submitting to some economic cooperation with it than by prolonging a conflict that could easily result in disaster for both groups.

Let's face it, Doctor: *Laissez faire* medicine has gone, and the hospital is here to stay. END

"Okay, who's the joker with cold hands?"

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What NOT to Put in Your Will

• Since most people are afraid of seeming long-winded in their earthly adieus, many wills are more notable for brevity than for clarity. Yet the fact is, the last thing you need fear is boring your beneficiaries. I have yet to see the reading of a will, however lengthy, where those affected by it did not hang on every word.

But if a free-flowing style is thus appropriate—at least in the informal, advisory passages—certain subjects are not. Some involve considerations of taste; for instance, elaborate recriminations. Others should be skipped because there's a better way to arrange execution of the testator's wishes.

Take the late and fictional Dr. Evans. His will clearly stated that he wanted to be buried in an inexpensive wooden coffin, with the simplest of services, attended by family members only. But his family, as is often the case, didn't see his will until after the funeral—a big public one, featuring Evans in a $500 embossed-bronze casket.

Moral: Your will is not usually the best place for burial instructions. It's better to give them separately to your family.

Often a testator will remember friends or employes with bequests of jewelry, works of art, or other personal effects. These are usually sentimental gifts and don't bulk large in the average man's thinking about his estate. If, after several years, he knows the main provisions of his will are still all right, he's not apt to review it merely to check over minor bequests.

The frequent upshot is that, by the time the testator has passed on, so have one or more of the minor legatees. Or some of the bequests may have become thoroughly inappropriate. In one recent case, the

By Rene A. Wormser, LL.B.

This article is the ninth of a series. The author combines a busy New York law practice with teaching, writing, and lecturing. He is moderator of the estate-planning course at New York University and author of such books as "Personal Estate Planning in a Changing World," "Theory and Practice of Estate Planning," "The Law," etc.

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family was upset to find that the deceased had left a valuable watch to an office aide he'd fired the year before for petty thievery.

Best policy is to avoid multiple minor bequests of this kind. Leave your personal effects to someone close to you, ordinarily your wife, relying on her to distribute them as you would have liked. You can tell her about it or leave her a note. It won't be legally binding; but, all things considered, it's generally the best bet.

Books and Instruments

Oddly enough, many doctors make no provision at all for their professional equipment, books, and patient records. Medical texts and equipment bring next to nothing at forced sale. Certainly some hospital, or some young M.D. just starting out, would be glad to get them. I generally recommend that professional equipment of this sort be handled in the same manner as personal effects, with instructions to place them where they'll do the most good.

What about your case records? If you're silent on the subject, your executor may simply burn them, possibly to the detriment of many of your patients.

A common solution among thoughtful physicians is to direct that such records be turned over to a colleague for distribution, at his discretion, to the patients' new doctors. However, this should not be done in such a way as to preclude the sale of your practice, records and all, if your executor finds this feasible.

Despite all that's been written on the dangers of unqualified cash bequests, they still keep popping up in wills. Tragic miscarriages of testamentary intentions can result. For example:

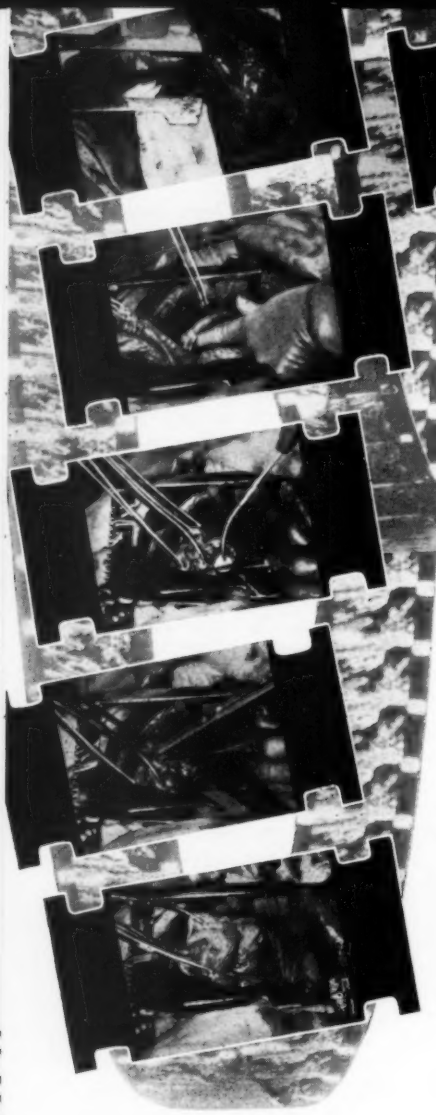
Dr. Harrison, as we'll call him, left "$15,000 to Nonesuch Medical College, and all the rest, residue, and remainder of my estate to my wife." When he made his will, he was worth close to $150,000. His obvious intention was to leave about 10 per cent to his medical school. But during his terminal illness, the bottom dropped out of his principal investments. His estate subsequently came to only $45,000.

The school still got its $15,000—a fat one-third of the total. Mrs. Harrison got $30,000, before taxes and other expenses. The staggering losses of the estate were compounded for the widow by a badly drawn will. At worst, she needn't have been left with less than $40,000, if the doctor had only qualified his school bequest thus: "$15,000 or 10 per cent of my residuary estate, whichever is less."

Surprise, Surprise

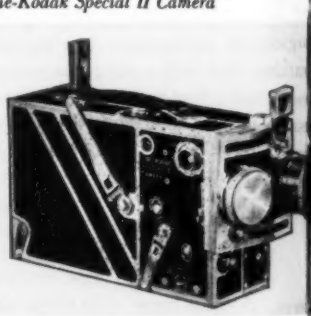
What other kinds of provisions are out of place in a will? Here are a few more garden-variety bloopers:

¶ Gifts of property that wasn't the testator's to give. If you live in



Reproductions from a motion picture; courtesy of the Birmingham Veterans Administration Hospital, Van Nuys, Califor

Cine-Kodak Special II Camera



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a community-property state, better check on what's yours and what (in the eyes of the law) is your wife's.

¶ Attempts to disinherit a spouse. It can't be done—at least, not by will. Almost everywhere, the survivor is entitled to a statutory minimum share of the estate, commonly one-third. Some states recognize *dower rights*—the use of any real estate by the surviving spouse for life.

¶ Attempts to leave it all to charity. Even if you're a widower, you may not be able to do this. Many states strictly limit charity bequests when there are *any* members of the immediate family living.

Above all, be sure your will contains no major surprises for your executor. Don't appoint anyone to this job without his knowledge and consent. If there are clauses that need explanation, go over them with the man. If you anticipate phony claims against the estate, warn him of them; advise him, too, of all probable legitimate claims. Explain the workings of your financial records. Show him your accounts-receivable file, to facilitate his collection of sums owed by patients.

Your executor will be your *alter ego* when you're gone. Better take him into your confidence ahead of time, while you can still be of guidance to him. If you can't trust him with the knowledge of your affairs now, perhaps you should ask yourself again whether he's really the man to be trusted later on. END

"We appreciate your donations, Mr. Jones, but the transfusions we have to give you afterward are breaking our blood bank."

A Quick Key to Personal Records

Organizing your personal papers for rapid and easy reference

• Of course you're keeping a duplicate of your declaration of estimated tax for 1951. But *where* are you keeping it? How long will it take you to find it? The time in seconds will give the inefficiency rating for your personal files. Is it further from zero than you care to admit?

You should hear about the doctor who can lay hands on a *patient's* record in two seconds flat, but has to call out a posse to round up a *personal* record that can chip $800 off his income tax.

As a first step toward efficiency, bulldoze your way through the papers stuffed into your desk and sort them according to whether you're saving them for:

a) Frequent reference or

b) Future reference.

You don't have to be a time-and-motion-study expert to know what to do next. Prescription #1 for your file-and-find program is: ***Put the most often used records in the most convenient place.***

But the problem of protection crops up as soon as convenience is under control. You may want to look through your stock certificates fairly often, but you're willing to sacrifice top-drawer convenience in order to keep them safe from fire and theft. So you write yourself Prescription #2: ***Put the most valuable records in the most protected place.***

Before your documents go into the safety deep-freeze, however, make stand-in lists. Have your secretary type up lists of insurance policies, stocks, bonds, and other investments, complete with all pertinent data, so you won't need to handle the originals.

After that, it's simple to route each of your records to one of three destinations:

1. ***For convenience,*** a set of filing folders in a drawer of your desk or in a file case next to it;

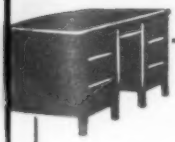
2. ***For safety,*** a fireproof, burglarproof safe in your office or a safe deposit box in the bank;

3. ***For occasional reference,*** another set of files that may be as far away as the attic or a closet shelf.

The safety question can be an-

[*Text continued on* 117]

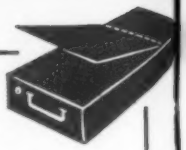
By H. C. Milius



In Desk or Filing Cabinet:

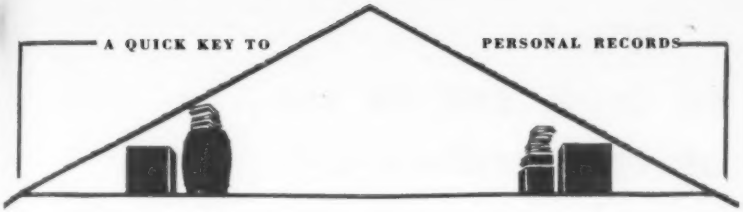
What	Why	How long
Current check stubs	As current expense record	Till all canceled checks received, then to dead storage or discard
Canceled checks	As receipts or tax vouchers	Till tax-return time, then to dead storage
Duplicate deposit slips	As proof of deposit, possibly as income voucher for tax use	Till bank statement received and verified, then to tax file or discard
Current bank statements	As proof of balance, deposits, withdrawals	Till verified against canceled checks and deposit slips, then to dead storage
Bills	For payment; some for tax use	Till paid, then to tax file or discard
Receipts	As proof of payment, some as tax vouchers	Two months, to cover crediting errors; then important ones to tax file, safe deposit, dead storage or discard
Current installment-purchase contracts	As reminder to pay	Till payment completed, then to dead storage
List of insurance policies, with premium-due dates	As reminder to pay, possibly for tax reference (some premiums tax-deductible)	Till revised
List of investments, with purchase prices	For reference in relation to investment program, tax problems	Till revised
Tax file (income, expense, deduction memos)	For tax use	Till tax-return time, then to dead storage

[*Turn page*]



In Safe or Safe Deposit Box:

What	Why	How long
Birth certificates; marriage and divorce records; guardianship papers; passports; social security card; unframed professional certificates, diplomas, licenses	Vital records	Permanently
Wills, powers of attorney or appointment	Vital instruments	Till revised, probated, or exercised
Partnership agreements, other professional or business contracts	Vital instruments	Till expiration
Real estate deeds, leases, registration receipts, title abstracts, surveyors' reports, utility deposit receipts, auto title, burial plot deed	As proof of title	Till sale of property or settlement of estate
Stocks, bonds, promissory notes, mortgages, other investments	As proof of ownership or claim	Till sold or collected
Receipts for payments on promissory notes, bank loans, mortgages	As proof of payment	Till evidence of indebtedness returned and destroyed
Insurance policies, with premium receipts	As proof of benefit rights	Policies, till collected or lapsed; premium receipts, till end of premium period
Inventory of personal and household property, with purchase prices	For reference in case of fire or other insured loss	Till revised



In Dead Storage:

What	Why	How long
Tax files for the past seven years, including duplicate returns and all supporting documents	For reference next tax-return time, or in case of Government review	Add latest file each year, discarding oldest
Old check stubs (optional)	As past expense record	Five to seven years, depending on state's statue of limitations
Old canceled checks (major withdrawals only)	As receipts or tax vouchers	Five to seven years
Old bank statements	As proof of balances, deposits, drafts	Five years
Old receipts (major purchases only)	As proof of payment	Five to seven years or till purchased item sold or discarded
Old installment-purchase contracts	As proof of terms	Till item sold or discarded
Equipment warranties	In case of claim	Till expiration
Equipment operating instructions	For reference	Till equipment sold or discarded
Family health records, inoculation schedules, prescriptions	For reference	Permanently
Keepsakes	You know why	Till you've forgotten why

[*Turn page*]

What to look for in an electrocardiograph today

When you plan to buy an ECG, you may find that various makes "look alike" to you. Further consideration, however, reveals important differences. Listed below are the things that make up these differences—and also make the Viso Cardiette today's foremost electrocardiograph.

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Leadership—Imitators of original Sanborn features thus acknowledge Viso leadership, but don't reach Viso standards.

Dependability—Making ECGs is not new to Sanborn Company—there's 28 years' development behind each Viso, and over 10,000 Visos in use today.

Quality—Only the finest materials and workmanship, found in the Viso, provide the precision that heart testing demands. The Viso is the FIRST ECG accepted by the Underwriters' Laboratories.

Accuracy—The Viso meets all recognized ECG standards, exceeds many of them. The FIRST to be accepted by the AMA Council on Physical Medicine and Rehabilitation.

Service—Thirty-one Sanborn offices assure continuously available expert service and close source of supply. And, you have constant contact by mail with the designers themselves.

Write for illustrated descriptive literature

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Fine diagnostic instruments since 1917

swered by your regular office safe, if it's fireproof. (Be sure somebody besides you knows the combination, for emergencies.) It has the advantage of being open for business with you at any hour of the twenty-four. A bank's safe deposit box, available from 9 to 2, is not so easy to get at, even though it is protected all the time against practically everything. What's more, it's sealed at the owner's death for tax appraisal. (There may even be red tape about getting a will out of it unless the bank knows the executor.)

In some localities, war precautions are already causing overcrowding in safe deposit vaults. So don't give protection priority to snapshots and baby shoes until your securities are safe from burning. Banks blush at some of the sentimental stuff stashed away in their vaults. Love letters and locks of hair lurk among the mortgages, silver loving cups crowd stock certificates, while applicants for safe deposit boxes have to be turned away.

Regardless of the availability of safe deposit boxes and the size of your home safe, you still want to separate and distribute your records for handiness. The desk-drawer files save heavy traffic in and out of the safe. That folder marked "Receipts" is a convenient catch-all for sales slips after cash purchases, receipted bills from the morning mail; it also helps you save the raw material from which tax deductions are made.

A separate place for records that you seldom refer to prevents overcrowding in your desk. It also saves you from fishing up a clipping about your college football prowess when reaching for an insurance premium notice. An Army foot-locker, an old roll-top desk in the attic—what's the difference where you keep these reference records? You don't look at them often.

The accompanying tables suggest a distribution that:

¶ Offers quick access to frequently used records,

¶ Gives protection to the irreplaceable, and

¶ Lets your keepsakes rest in peace.

For anything that doesn't have a reserved parking place, remember—there's always the wastebasket. END

What Makes a Bad Debt Bad?

Here's what the Federal income tax law says about deductible debts

It's a dark, moonless night. The hill wind is pounding the window ane. The clock on the wall strikes idnight. Slumped over his desk is graying, prosperous-looking phy- ician.

The setting for a mystery story? o—a tax story. The prosperous- oking doctor (who's feeling any- ing but prosperous at the mo- ent) is working out his 1951 Fed- al income tax.

Suddenly, he sits up hopefully. Aha!" he mutters optimistically. Deductions for bad debts, eh? Let's e. There's poor Mrs. Murchison— u can't blame her, of course—but e *does* owe me $150 for that op- ation."

Stop right there, Doctor. Can you *really* deduct those bills you haven't been paid for professional services?

The answer, of course, is no. The uncollected fee does *not* qualify as a bad debt. Reason: Such bills are not usually entered as income in the first place. You get no deduction because you paid no tax on them previously.

To count as a legitimate deduction, a bad debt must ordinarily involve money that you have advanced on an unconditional promise of repayment. And it must have be-

---

By Alfred J. Cronin
The author is a member of the firm of Murphy, Lanier & Quinn, public accountants.

A new case history with pictures

The unique value of Dexamyl* in providing symptomatic relief fro mental and emotional distress is clearly demonstrated in this ca history—from the file of a Philadelphia general practitioner.

Patient: T.H. (shown in photos on opposite page), age 62, widowed, father of 6 children, afflicted with arteriosclerotic, hypertensive, cardio-renal disease. Although basically a fine individual, he had become "a typical alcoholic".

"His emotional balance became seriously disturbed and he would cry and exhibit depressive characteristics, with or without intoxication ... His mood would rest on a hair ... His nausea, vomiting and inebriety; his emotional outbursts, depression and constant reiteration; his carelessness of personal habit; ... all of these had gradually decreased the love of his children for him."

Medical Treatment: Dexamyl — 2 to 4 tablets daily.

Results: "Adequate dosage decreased the demand for liquor and gave him an increased sense of well-being. Emotional balance was more easily sustained daily habits were more normal. His personal life became less objectionable to his family. Sleep, for the first time in years, was more tranquil."

Dexamyl

its "normalizing" effect

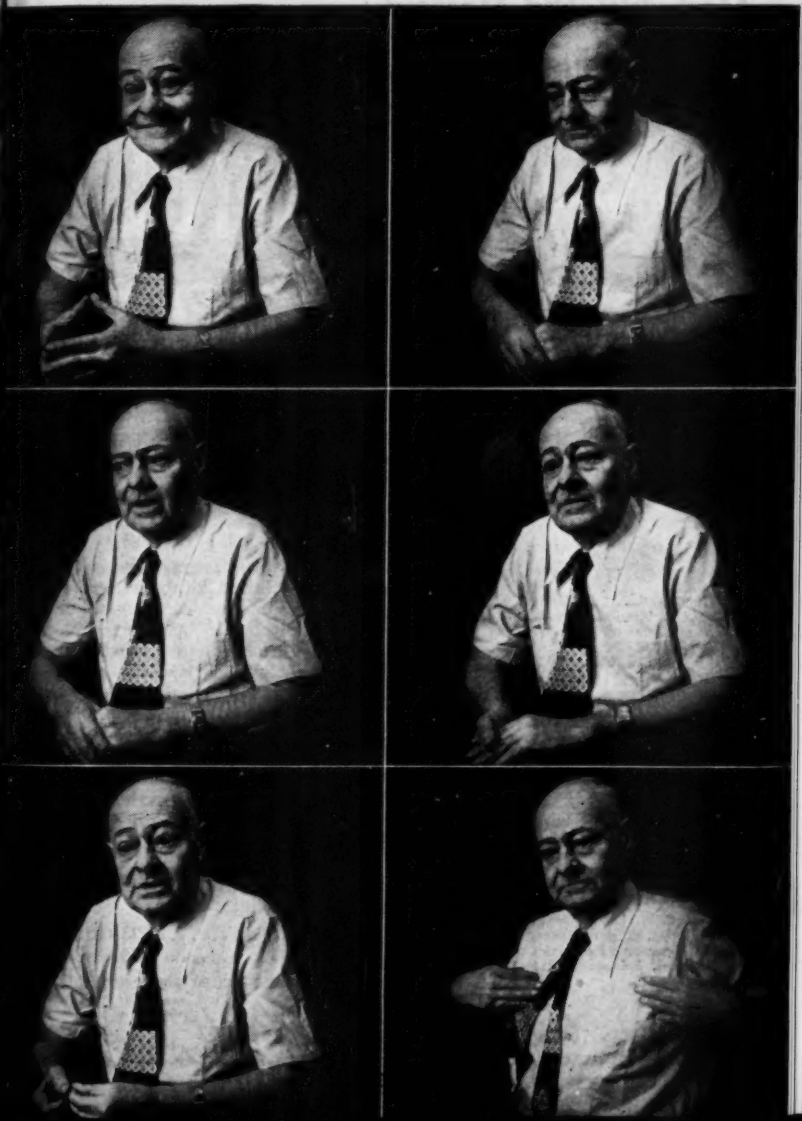
ameliorates mood . . . relieves inner tension

Each tablet contains Dexedrine* Sulfate, 5 mg.; amobarbital, Lilly, ½ gr. (32 mg

*T.M. Reg. U.S. Pat. Off.

Smith, Kline & French Laboratories, Philadelphia

These unposed photographs of patient T. H. were snapped during an actual interview with his physician. He is describing his symptoms of mental and emotional distress. See the opposite page for the case history of this patient.



In Coronary Atherosclerosis... Morbidity and Mortality can be reduced with

SOLUTION SIRNOSITOL

CHOLINE AND INOSITOL

In a report of a three year study of 115 cases of coronary atherosclerosis, a marked reduction in mortality was noted after prolonged lipotropic therapy as compared to the mortality among an equal number of untreated controls.[1] The efficacy of lipotropic agents in the treatment of coronary atheromatosis may be due to their ability to reduce the serum levels of cholesterol and other lipids which are considered to be of etiologic importance in atherosclerosis.[1, 2, 3]

A Synergistic Combination—Both choline and inositol, as provided by Solution Sirnositol, are synthesized into the phospholipid complex—choline into lecithin and inositol into other liver phospholipids. The role of choline and inositol in the maintenance of phospholipid levels has a stabilizing and dispersing effect on the esterified cholesterol fraction in plasma.[3] A natural synergism enhances the lipotropic effect of choline and inositol administered in combination, thereby also enhancing the therapeutic results.[4]

High Dosage—Satisfactory therapeutic response occurs only with an adequately high dosage of choline and inositol. Solution Sirnositol provides an aqueous, sugar-free, highly palatable and potent means of lipotropic therapy. The daily dose of three tablespoonfuls provides:

Choline gluconate	22.23 Gm.
Inositol	2.25 Gm.

Available in 16 oz. bottles, on prescription only.

REFERENCES

1. Morrison, L. M., and Gonzales, W. F.: Results of Treatment of Coronary Arteriosclerosis with Choline, Am. Heart J. *39*:729 (May) 1950.

2. Morrison, L. M., and Wolfson, E.: The Effect of Lipotropic Agents (Choline, Inositol) and Estrogenic Hormones on Serum Lipid Fractions, Circulation *2*:479 (Sept.) 1950.

3. Leinwand, I., and Moore, D. H.: Simultaneous Studies on the Serum Lipids and the Electrophoretic Pattern of the Serum Protein in Man: (1) Action of Inositol and Other Substances, Am. Heart J. *38*:467 (Sept.) 1949.

4. Best, C. H.; Lucas, C. C.; Patterson, J. M., and Ridout, J. H.: Lipotropic Properties of Inositol, Science *103*:12 (Jan. 14) 1946.

C.S.C. Pharmaceuticals

A Division of COMMERCIAL SOLVENTS CORPORATION, 17 East 42nd Street, New York 17, N. Y.

come worthless during the taxable year. (If the debt had no value at the close of 1950, or if there's a chance it will be repaid in 1952, you can't deduct it on your 1951 return.)

In listing any such bad debts, be ready to *prove* that the money can't be recovered. The Internal Revenue people may ask you for evidence that you've made a real effort to collect—including legal action, if the amount of the outstanding debt is substantial.

All told, the tax law recognizes three classes of bad debts: (1) corporation and other bonds that became worthless during the year; (2) business or professional bad debts; and (3) non-business bad debts.

Worthless Bonds

Fully worthless bonds are deductible as capital losses. Whether you should claim the loss as short-term or long-term (over six months) depends on your date of purchase. The date of worthlessness is always taken as the last day of the year, no matter what date during the year the bonds became wallpaper. Incidentally, such bonds must be registered or in interest coupon form.

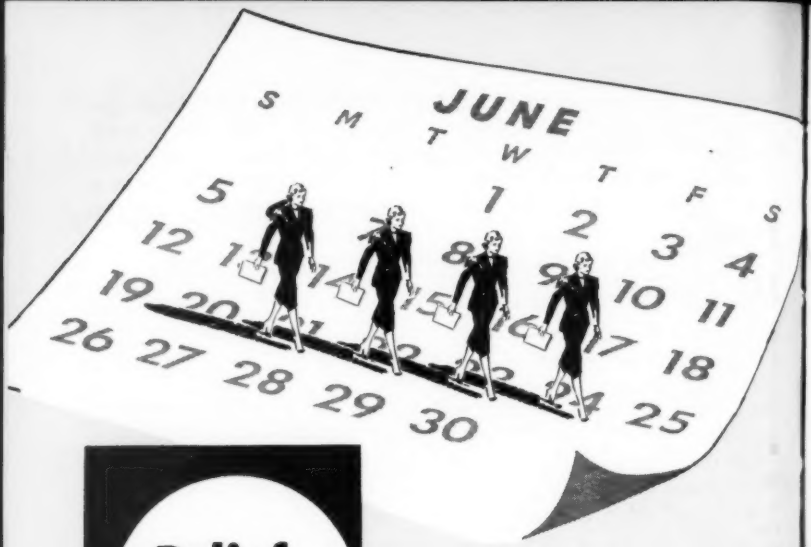
Unrepaid advances connected with your practice may be deducted on your Federal income tax return for the year in which they go sour. For example, suppose you paid $500 to a medical equipment supplier earlier this year, and the equipment was never delivered because the supplier went broke. You're stuck as far as the outlay is concerned; but you *can* deduct the loss on your tax return for 1951 as a business bad debt.

Non-Business Debts

Bad debts not connected with your practice are also deductible. A personal loan gone bad, like that $300 advance Mr. X never repaid before leaving for parts unknown, is an example. If you've compromised a loan—for example, if you were forced to accept $100 as repayment in full for the $500 you loaned Mr. Z—the difference can be subtracted from your taxable income. Claim these losses on your Federal tax form as short-term capital losses.

In connection with these personal loans, many an M.D. fails to keep careful enough records. Being by nature sympathetic, he is the target of frequent (and usually genuine) hard-luck stories. Yet if he digs into his pocket, he's apt to forget it by tax time. That merely compounds his financial loss.

Note, however, that not every personal handout counts as a deduction. That "loan" to your brother-in-law may not qualify; nor will the $50 you slipped to a down-and-out friend. If you didn't really expect to get your money back, the transaction is called an outright gift. And the Revenue agents call 'em as they see 'em. END



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The recurring discomforts of Dysmenorrhea can be minimized with the aid of Anacin. These tablets relieve the pain quickly and for a great duration of time, yet they are well tolerated and easy to take. Anacin is the dependable APC formula that so many physicians prefer because these tablets produce a mild degree of sedation in addition to their analgesic effect. Anacin is available at all pharmacies. If you would like to have samples of Anacin, please make your request on your letterhead.

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Jottings From a Doctor's Journal

By Martin O. Gannett, M.D.

• Just a year ago, Mrs. Nehf, an assiduous syphilophobe, brought in a plump, apple-cheeked Pennsylvania girl—her new maid—for a Wassermann. As on previous occasions, Mrs. Nehf felt the need to apologize for the precaution. "You understand, Doctor, I'm sure. We have to live in the same house, after all; and we can't be too careful."

The youngster turned out all right, and that was the last I saw of her until two weeks ago. She came in by herself this time, and it took a third glance to recognize the milk-and-honey girl in this gaunt, hectically flushed face. She had been told she couldn't stay on if she didn't stop coughing, and she couldn't stop.

The apical shadow and the Gaffky count were not really a surprise after the physical examination. It turned out, after some field work, that Mr. Nehf had tried three sanatoria and had found them wanting. He preferred to nurse his tubercle bacilli in the comfort of his own home.

• • •

The causes of sterility are many. I was explaining to Mrs. Werner the successive steps I had in mind for isolating the nature of her difficulty when she stopped me. "Doctor, I see I'll have to tell you the whole story."

It appears that even with a history of six years' married life, one must still consider celibacy as a possible cause of childlessness.

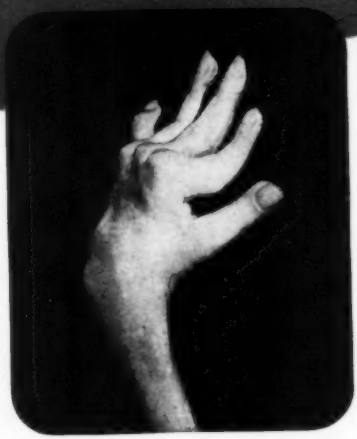
• • •

Colleague Frank Metzger relays this one . . .

It was 4:30 P.M. My patients and my patience were thinning out. The secretary brought in a man and wife, accompanied by two children. The youngsters, I was told, had asthma.

I started to take a history, but was stopped short. The kids' mother took off on a verbal non-stop flight: home-spun etiology, rhetorical questions, remedies by the dozen, but rarely a symptom. Three times I opened my mouth, then shut it again. Once I got in four words before she drowned me out.

I leaned back, lit a cigarette, and waited for anorexia to come to my rescue. Somehow my mind wandered back to all those admonitions I'd read in the medical texts: "Get a good history—let the patient



The TIME-TESTED Steroid

in

ARTHRITIS THERAPY

Science continues to seek a cause and a cure for the arthritic syndrome. But it takes time to evaluate the effectiveness of new agents, such as the recently developed steroids and steroid stimulants.

For the arthritic sufferer who can't wait but needs relief NOW, the pioneer in the field—time-tested Steroid Complex, Whittier—ERTRON®—is available for use now.

For fifteen years Ertron has been tested clinically in thousands of cases. Throughout that long period, Ertron therapy has been notable for giving sustained relief from the swelling, stiffness and pain of arthritis.

Ertron is a potent drug, and like all potent drugs, should be administered only under the direction of a physician who will determine compatible dosage levels.

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ARE ESSENTIAL IN CONSTIPATION MANAGEMENT

In KONDREMUL, each micro-globule is coated with a tough film of chondrus which resists gastrointestinal enzymic action—yet KONDREMUL pours freely from the bottle, is of velvety softness.

KONDREMUL, being finely subdivided, contributes soft bulk to the dry fecal residue, easing elimination and encouraging regular bowel habits.

KONDREMUL Plain (containing 55% mineral oil).
KONDREMUL with non-bitter Extract of Cascara (4.42 Gm. per 100 cc.)
KONDREMUL with Phenolphthalein—.13 Gm. (2.2 grs.) per tablespoonful.

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Also in tablet form
KONDRETABS

—the original Irish Moss—Methyl Cellulose Bulk Laxative in Tablet Form.

KONDRETABS induce soft, easily eliminated bulk—no bloating, griping, impaction. Convenient, pleasant, easy to take.

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talk." So I was getting a good history, I consoled myself. Alongside of *my* historical works, "The Decline and Fall of the Roman Empire" was going to look like a synopsis.

Suddenly the husband cut in sharply: "Mary, will you shut your damn mouth! And keep it shut! I've driven a hundred miles to hear what this specialist has to say about these kids, and you haven't let him open his mouth. I can hear you at home whenever I want and lots of times I don't want. Now, let's hear from the doctor."

"*Well!*" she gasped. "I was just trying to help him out."

"If I thought he needed any help from you, we wouldn't be here." And, to me: "Will you take over now, Doctor?"

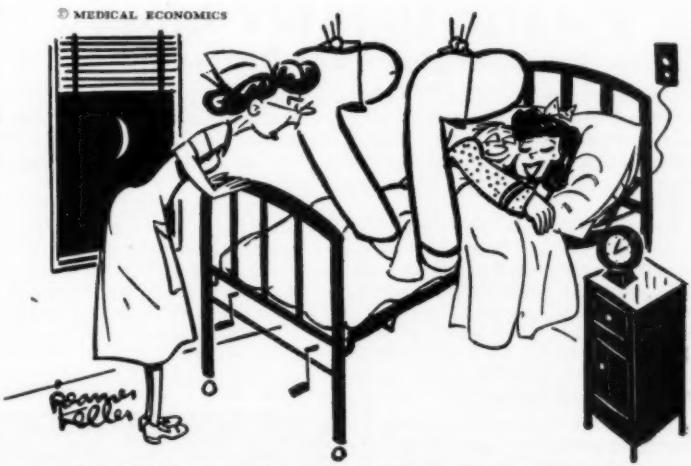
I did—with new hope for the race of man.

• • •

Marc Aspen's admission diagnosis of hysteria was retained during his two weeks' stay in the ward. Nothing in the course of his work-up tended to modify it. It was the diagnosis he died with yesterday.

The embarrassment of the affair has been brought into sharp focus now that the autopsy, too, has revealed nothing to change the diagnosis.

The death certificate has yet to be filled out. END



"Mr. McNeil, how often must I tell you that you can visit your wife only between 7 and 8!"

Want to Invest in a 'Taxpayer'?

As real estate investments go, store buildings offer fair returns, few headaches

● In the depression of the 1930's, many land owners faced loss of their holdings through default of taxes. In desperation, they put up the least expensive structures they could, asking only enough rent to meet tax bills. Thus was born the kind of real estate investment still called a taxpayer—the now ubiquitous one-story building designed to accommodate one or more retail shops.

These days, of course, it will do a good deal more than cover your taxes. Net returns of 6 to 8 per cent are not uncommon. Some run much higher.

That's still less than you can often get on other types of property—office buildings, for example, or apartment houses, or industrial structures. But most of these involve considerably more risk. And all take a lot more of the landlord's time.

Note, for example, the problems confronting the owner of an apartment house or office building. Rent collections from his numerous tenants are a monthly headache. Somebody's leaky radiator always needs fixing. Somebody else wants his place redecorated. A superintendent or janitor is necessary—perhaps a rental office, too.

Not so with a taxpayer. Inside maintenance is ordinarily up to the tenants. And since there are relatively few of them, the owner doesn't need an agent to collect his rents. What's more, he can be reasonably sure that he *will* collect them.

That's because taxpayer tenants are usually retail merchants. Retail trade (especially in clothing, food, drugs, and other necessities or common amenities) rides a fairly even keel through both good business weather and bad.

In other lines of business, it's more apt to be a feast or a famine. When a depression hits, small manufacturers go broke by the hundreds. The owner of a loft building

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By Leonard J. Meiselman, LL.B.

The author is a New York attorney specializing in real estate law. He is a lecturer on the subject at Brooklyn College and counsel to such realty organizations as the United Real Estate Owners Association and the American Home Owners Corporation.

or a small manufacturing plant may find himself without a tenant for months, or even years. With an office building, too, depression occupancy may sink below the break-even point.

Consider the investor who bought a Manhattan block front for $3 million in the late 1920's. He figured on putting up a skyscraper. Came the crash, and he had to postpone the idea; for skyscrapers all over town were soon standing half-empty.

Burdened with a $2 million mortgage and a $60,000 annual tax bill, he built a multiple-unit taxpayer. Space was promptly rented to a drug store, a restaurant, a shoe repair shop, a dry cleaner, and several other stores. As conditions improved, his return rose from an initial 3 per cent to nearly 15 per cent. Today he has an architect busy on the delayed skyscraper.

Not that investing in taxpayers is a sure thing—not by any means. Even the best-entrenched retailers have their ups and downs. And if any tenants represent new enterprises, there's always the question of how their businesses will fare.

That's why the so-called percentage lease is a common arrangement. The idea here is to set a moderate

"What nerve! He has her on his expense account under 'teaching aids'!"

basic figure, then share in whatever growth the tenant's business may later enjoy. A typical rent clause might look like this:

(a) The tenant shall pay a flat $250 per month.

(b) In addition, the tenant shall pay an amount equal to 6 per cent of his first $50,000 of annual sales; plus 4 per cent of his second $50,000 of annual sales; plus 2 per cent of his third $50,000 of annual sales; plus 1 per cent of annual sales in excess of $150,000.

Customary percentages vary according to the type and size of the business. Your local real estate board can supply tables of recommended figures, useful as a guide. A mutually satisfactory percentage lease makes for harmonious relations with tenants, an important factor in successful realty investing.

Even more important is your taxpayer's location. Tenants won't prosper if it's situated outside the shopping pattern of the town or neighborhood. You could even find yourself less than fully rented—a far more serious matter with a taxpayer than with a fifty-tenant office building.

The Right Spot

How to check the location before you buy or build?

If it's an urban site, the volume of pedestrian traffic past your door is important. So is the adequacy of transportation. If shoppers come in cars, ample and convenient parking facilities are vital. Here's a case in point:

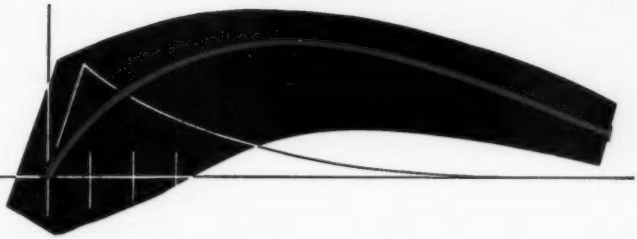
An investor in a busy suburban shopping area decided there was room for another supermarket. The existing market was doing a gross weekly business of $27,000—without benefit of a parking space. A sizable parking lot was provided right next to the new building. Result: The second supermarket was soon grossing $40,000 a week, while the first one dropped to $12,000.

But remember that shopping areas, like residential districts, may grow obsolete. New housing developments, shifts in population-density centers, new highway construction, extension of transportation lines—they're all significant. In one of New York's outlying boroughs, for instance, the vicinity of a newly opened subway spur is fast becoming one of the highest-valued business areas of the city.

Case History

Biggest bonanzas go to the investor who correctly analyzes the shifting tides of values, and acts accordingly. Take the case of Dr. Williams, as we'll call him:

For years he'd been taking the same route from his office to the hospital. This included a two-block jog over Elm Street, a quiet thoroughfare well removed from the center of town. For as long as he could remember, Elm Street had looked about the same: on the left, a row of high-hipped, old fashioned



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ACTHAR *Gel*, the new LONG-ACTING repository preparation for deep subcutaneous and intramuscular injection, greatly facilitates ACTH therapy for both the patient and the physician. A single daily injection is sufficient in the many cases requiring less than 80 I.U. (mg.) per day. Remission of symptoms may often be maintained by two to three injections per week. Office treatment for the ambulatory patient and home treatment for the bedridden become readily applicable, with considerable economy to the patient. ACTHAR *Gel* is well-tolerated locally and possesses the full efficacy of aqueous ACTHAR.

Indications: Rheumatoid arthritis, rheumatic fever, acute lupus erythematosus, drug sensitivities, severe bronchial asthma, contact dermatitis, most acute inflammatory diseases of the eye, acute pemphigus, exfoliative dermatitis, ulcerative colitis, acute gouty arthritis, secondary adrenal cortical hypofunction.

Literature and directions for administration of ACTHAR *Gel*, including contraindications, available on request.

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peptic ulcer

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- **IN PEPTIC ULCER—To speed healing and recovery, it is logical to relieve vascular spasm, restore normal circulation to the gastric mucosa and to reduce gastric hypermotility. By selective action on the vagus, Lusyn provides smooth and dependable spasmolytic action without the side effects so often seen with atropine and belladonna. The buffering and adsorbing action of Lusyn combats the acid-pepsin factor.**
- **IN PYLOROSPASM—usually associated with peptic ulcer—the spasmolytic action of Lusyn overcomes the tendency for retention of highly-acid gastric contents.**
- **IN SPASTIC COLON—Lusyn has an inhibitory effect on the parasympathetic system...gives symptomatic relief from cramps and spasm and allays commonly associated psychosomatic influences.**

Dosage: Usually, 1 or 2 Lusyn tablets before meals. Because of its wide safety margin, Lusyn dosage may and should be increased in the more obstinate cases.

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SPASMOLYTIC — ANTACID ADSORBENT

SEDATIVE:

Maltbie Laboratories, Inc.,

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houses; on the right, mostly empty lots. Within the past year or so, however, the street's character had begun to change.

There was more traffic, and parking meters had been installed. A number of gleaming new stores had gone up on the empty lots. More and more shoppers were in evidence, apparently from the new ranch-house development a few blocks farther on. The state highway, formerly passing through the middle of town, had been re-routed along Johnson Avenue, only a block over. A new bus line traveled this part of Elm before turning up to Johnson.

The largest of the new stores stood on a corner, and across the street from it was a row of ancient houses long since descended to a condition of genteel squalor. Obviously, they had outlived their time. A new traffic light had just gone up at the corner, facilitating pedestrian crossing at this point.

The doctor mulled it all over a few weeks, then stopped at a real estate office and got a price on the property. It wasn't unreasonable. He had the realtor make inquiries among some of the town's merchants who might be interested in moving to the site. Out-of-town store owners were also contacted. The response was encouraging.

The doctor bought the property, tore down the old houses, and erected a four-unit taxpayer. Before it was even finished, he had his tenants—a women's-wear shop, a confectionary store, a toy store, and a jewelry shop. Today he's earning from 20 to 22 per cent on his investment.

Tenants and Prices

It usually pays, incidentally, to be pretty choosy about your tenants. Never accept one without checking his business record. Inquire around about him. Get a credit-rating report. And make reasonably sure that his type of business will fit into the commercial pattern of the neighborhood.

The owner of one brand-new taxpayer lost heavily for his oversight in this matter. Without thinking much about it, he rented to a drug store, although another stood directly across the street. The two soon got into a price war, with the newcomer finally going bankrupt. It cost the landlord $10,000 to redesign his store front for another tenant.

Suppose you're buying a ready-built taxpayer—what's a fair price?

First, decide what's a satisfactory return on the building. Consider its location and tenants. A building in a first-class spot with a first-class tenant (a national retail chain, for instance) represents gilt-edged value. On an investment of this kind, in most areas, you can't expect much better than 5 or 6 per cent.

In a less desirable location, or with less dependable tenants, you can insist on a higher return, since

AT THE FIRST SNEEZE

That's the sign for SYNTHENATE TARTRATE therapy ... for in the early phase of coryza, this simple treatment brings gratifying, often dramatic relief.

In 65% of cases complete remission of symptoms occurs within fifteen minutes after injection of 1 cc of SYNTHENATE TARTRATE-Breon, when administered within twenty-four hours of the first sign of a cold!

Injection is simple... relatively nontoxic... prolonged in effect. SYNTHENATE TARTRATE-Breon increases cardiac efficiency and frequently slows the pulse rate; thus it is effective without appreciably increasing the work of the heart. It does not cause cardiac arrhythmias, does not stimulate the central nervous system, does not produce signs of anxiety.

DOSAGE: 1 cc injected intramuscularly or subcutaneously ... repeated in 3 or 4 hours, if required.

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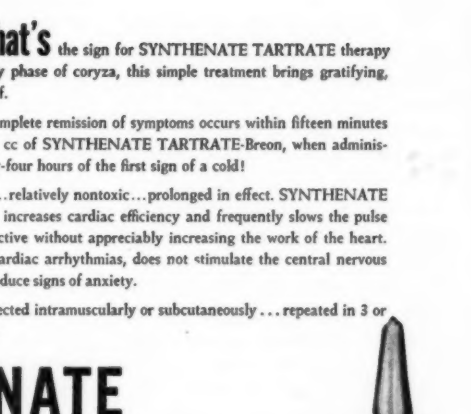
Available at all drug stores. 1 cc ampuls — boxes of 12 and 25.
Complete literature to physicians on request.



BREON

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your risk will be greater. A little study of the situation will help you fix a figure. Let's say it's 9 per cent.

Next step is to *capitalize* the property's earning power. Suppose it's netting the current owner $7,300 a year. Will it keep on earning that much?

Here you must allow leeway for ups and downs in the general business picture. Allow too for possible shifts in the local realty situation. Let's say you decide that $6,300 is a fairer estimate of the building's average annual earnings over the next ten years or so.

Since you want a 9 per cent return, let $6,300 equal that percentage figure. Then 1 per cent will equal $700, and 100 per cent—your estimated fair price for the building—will be $70,000.

Now compare this figure with:

¶ Asking prices of comparable taxpayers around town.

¶ Prices actually obtained in recent *bona fide* and non-forced sales of comparable properties in the vicinity.

¶ Value placed on the building by a competent appraiser—and also his estimate of reproduction cost, less depreciation.

In the light of these findings, you'll probably want to revise your initial price estimate somewhat. Perhaps $75,000 now looks like a more realistic figure. However, that may still leave you considerably below the asking price—say $87,500.

Almost certainly, you'll find the owner ready to bargain. Whether you finally settle at a figure closer to his than to yours will depend on your respective talents as horse traders; how much you want the property; how badly he wants to get rid of it; and local supply and demand.

But a word of warning: Before you begin final discussions on price, be sure you know *all* the facts about the property. Study the owner's records for several years back. Accepting a single year's figure as typical may let you in for a nasty jolt later on.

Remember the fellow who bought a taxpayer at a price based largely on its operating results over the past twelve months. He'd been pleased to find, for example, that the coal bill had amounted to only $500 that winter, which had been a fairly cold one. Subsequently and sorrowfully he learned the reason: Heating costs for the year had been low only because a lot of coal had been carried over from the preceding winter—which, as the new own-

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er had forgotten, had been unusually warm.

The moral? Simply that there's no such thing as a sure-fire investment, even in taxpayers.

But for the doctor-investor willing to study the angles, this type of property offers attractive opportunities for income and profit. Best of all, once a purchase is made, it demands little of the owner's time.

END

Brave Bull shown above is up against a brave M.D. But it's "strictly a hobby," says Dr. William H. Bloom, who doesn't plan to give up medicine for the cape-and-banderilla specialty.

He saw his first bullfight a year ago, while doing Navy duty in towns near the Mexican border. He was immediately enthralled by the sport. To pick up some of the fine points, he visited several "tientas" (testing grounds for young calves) during his off-duty hours. Last June he made his formal bow in a bull ring. A month later he was credited with his first kill.

"There's no thrill to compare with facing a charging bull," says the young M.D. The only hitch: It's a hard avocation to keep up. Now stationed conveniently at San Diego's U.S. Naval Hospital, Dr. Bloom is due soon in New York for a neurosurgery residency. He'll be a long way from the nearest fighting bull.

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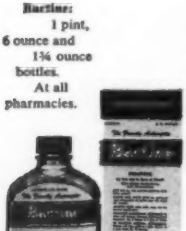

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Ins and Outs of Insurance Work

Medical examining can be a good sideline, but the new fees may not mean more income for the doctor

● Examining applicants for life insurance isn't one of the glamor jobs of medicine. But it pays more than pin money to a surprisingly large number of physicians. The fact is, an estimated 50,000 (most of them G.P.'s) earn upwards of $15 million annually from life insurance companies.

For a few doctors, this work brings in the bulk of their income; for some, it's a negligible item. But for most examiners, it's a good, steady sideline that has aided them in building practices, underwritten specialty study, helped tide them over hard times.

Take the experience of a young M.D.—we'll call him Fred Rhodes—who recently set up practice in a large midwestern city. A life insurance company assigned him the pleasant task of examining a group of fashion models who were taking out policies. ("I'd have paid the fees myself for the privilege," grinned model-examiner Rhodes.)

One thing led to another, and today Dr. Rhodes does most of the medical work for the model agency's employes. The girls pose outdoors in all kinds of weather and contact quite a few minor ills. For treating these, he averages better than $100 a month.

More typical is the case of a gynecologist in New England. During his first seven years of general practice he did insurance examining and put the money aside. The day came when he could afford to take time out for a postgraduate course in gynecology. Returning to practice two years later, he resumed insurance work until he was certified and established in his specialty.

Actually, this is the pattern most insurance companies prefer. They like an examiner who starts young. When his own practice gets too busy, he's expected to turn over his insurance work to another budding M.D.

Of course, it doesn't *always* happen that way. One company found recently that among its small-town examiners was a 91-year old. Another company had trouble persuading a $25,000-a-year surgeon in

By James Fuller

Pennsylvania to let a younger colleague handle the examinations that were bringing him $1,200 a year.

Examiner's Income

How much money is there in it for the average M.D.? Probably no one knows except the average M.D. whoever he is. But there's a revealing clue in this breakdown of the annual payments of one of the biggest companies to its 8,500 examiners:

About 100 of these men are paid from $5,000 to $10,000 a year, but do very little other practice. About 1,200 earn from $1,000 to $5,000. There are about 2,000 in the $300-to-$1,000 bracket. The remaining 5,000-odd make less than $300 each from this one company. In the last two groups, however, are many physicians who practice in sparsley-settled areas. Each of them may represent a dozen or more companies.

In most cases, therefore, the monthly checks are sizable enough to plow back into one's own life insurance or retirement program, as many G.P.'s do, or to send a couple of sons through medical school, as an upstate New York physician has just done. Others report that they earmark their insurance fees for rent, vacations, new equipment, and the like.

Most significant development in this field is, of course, the recent increase in examination fees. Three years ago, state and local medical societies, beginning with Rhode Island, began asking the companies to raise the standard $5 fee, which had been stationary for half a century. The A.M.A. picked up the torch, made a survey, but passed the negotiating job back to the societies to avoid running afoul of the anti-trust laws.

Increased Fees

The campaign succeeded, and today more than 100 of the largest companies (handling 96 per cent of all life insurance business) have raised their fees. In almost every case, it was a 50 per cent raise—from $5 to $7.50 for the basic exam. Other fees, such as those for special heart examinations and for additional blood-pressure and pulse readings, were graded up proportionately.

But will increased fees add up to more money for examining physicians? It's by no means certain. In fact, one of the top companies recently reported that in the first three months under its new fee schedule, "there has been an overall reduction of 28.5 per cent in fees paid."

Predicting that this trend will continue, the company softened the blow with this curious remark: "It will afford considerable relief to practicing physicians from the demands we have made on their time. It will permit them to devote more time to a practice which will

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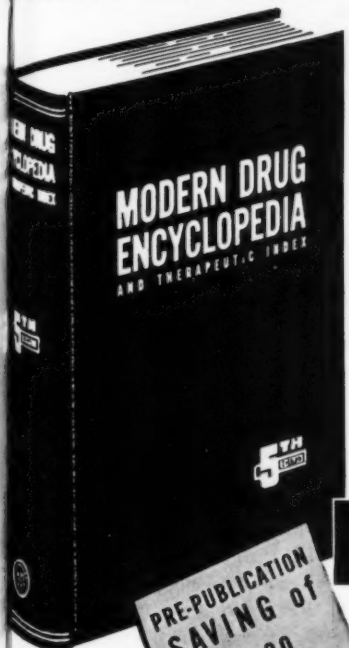

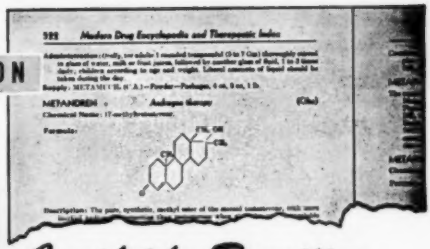

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grow because of the increasing relative shortage of physicians."

Why this sudden decrease? The reason is that when they increased fees, many companies also relaxed their rules on nonmedical insurance. Thus they were able to cut down on the number of required examinations. They could do this because mortality trends today permit about half of all new insurance to be written on a nonmedical basis without undue risk. In fact, few policies up to $2,500 on applicants under 45 now require exams.

Income in the Future

But reduced doctor income from insurance examining has by no means been universal. One company, for example, reported that in the year following the fee hike its fees to examiners rose 20 per cent. Best guess about the future is that there will be fewer examinations to make, but about the same amount of money in insurance work as before.

Despite its attractions as a sideline, insurance work is not entirely a beer-and-skittles routine. As a home office medical director put it: "The examining physician is in a highly exposed position—between the local agent, the applicant, and the far-off home office. His loyalties are divided and are hard to reconcile." The agent is hell-bent to make a sale. The applicant (who may also be a patient) is more apt to conceal than reveal his medical history. And the home office has a fishy eye for risks, no matter how hard it rides the agent.

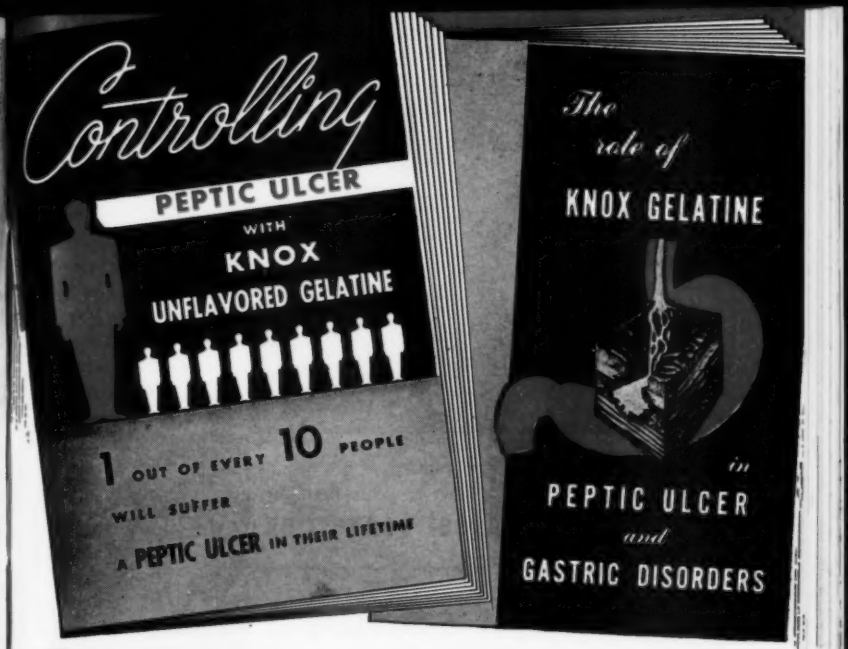
Occasionally, too, an overzealous agent may urge the doctor to mark down the applicant's blood pressure or scale a little off his weight. But this sort of thing probably doesn't occur as often as it used to, mainly because prospects with physical handicaps can now often get extra-rate life insurance.

Examiner's Ethics

Suppose the examiner knows of an old gastric-ulcer history that the applicant-patient has conveniently forgotten? Suppose he knows that the father died of TB, not of pneumonia, as the applicant claims? Are these facts confidential or is he bound to report them to the company? Strictly speaking, the company is entitled to them.

In this dilemma, one medical director suggests two courses for the M.D.: (1) He can disqualify himself and let another physician give the examination. (2) He can submit the full details separately from the examination form.

Though perfunctory work by examiners is the biggest complaint of the home offices, it sometimes happens that a doctor is *too* eager. That was the case with one practitioner whose rejection rate on his exams was 17 per cent (normal rate is about 5 per cent). Finally, with its agent screaming for blood, the company investigated. It found



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that the M.D. had an idea that a good proportion of applicants for insurance were frauds. So he simply kept probing till he found something wrong with them.

The standard insurance exam is really supposed to be a gross screening procedure. The home office wants complete, prompt answers to its questions. But its own experts do the prognosis, are responsible for accepting or rejecting the applicant. For that reason, most companies don't want the doctor to bother his head about the mysteries of underwriting and risk selection.

An examiner, for instance, may sometimes raise the roof because an applicant in good physical shape was turned down. But as an insurance company officer explains, "Maybe we found out that he was sleeping with another man's wife and was in danger of getting shot."

What qualifications do medical directors look for in picking examiners? In general, they say: "We prefer a physician who's under forty, is a graduate of a first-class medical school, has completed a satisfactory interneship, and is in general practice or specializing in internal medicine. We like him to be a medical society member, and he must naturally be of good standing in his community."

Though recommendations by the agency force or by other examiners are often followed in employing examiners, the best way for the individual physician to get an insurance connection is simply to apply to the company medical director.

As a rule, physicians clamor for insurance work during depressions. In boom periods and during wars, they're somewhat less interested in it. Some companies say they have had trouble getting examinations done ever since 1941. This seems to indicate that, while there's no fortune in the work, it still offers opportunity to a good many practitioners. END

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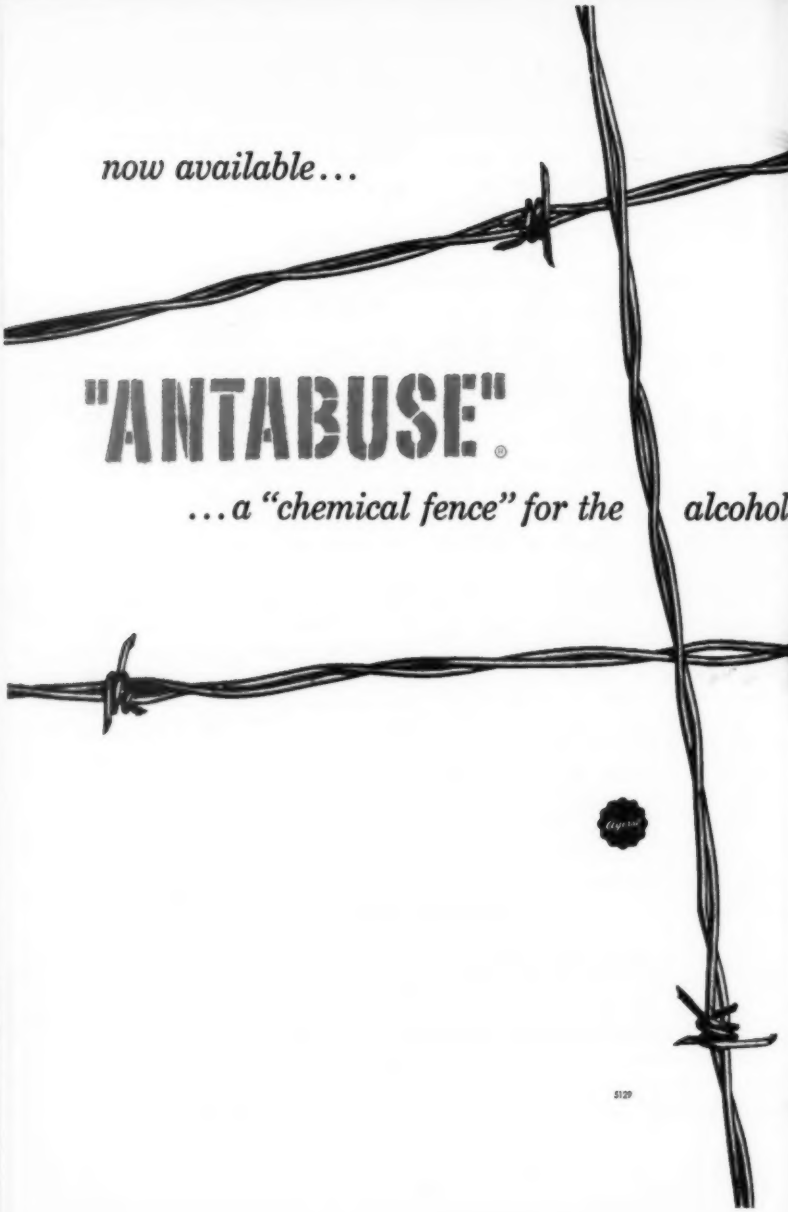
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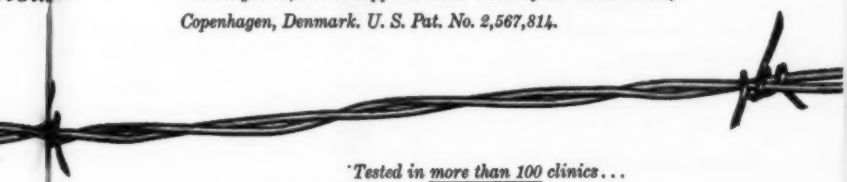

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Letter From Tangier

● Do you ever get tired? I mean weary from your growing tax load? And from the razzle-dazzle competitive life you've been trying to live up to?

I see a showing of hands. They belong to doctors who, once in a while, permit themselves the day-dream of a not-too-remote and kindly spot where the tempo of life is more leisurely. Where no one keeps up with the Joneses. Or nurses an ulcer.

Let me introduce you to such a place:

Tangier lies clean and cool and white, sprawling in the sun on the summer coast of Spanish Morocco. On a clear day you can look across the strait and see Gibraltar. For a mental picture of it, don't think of movie actors and the Casbah. Imagine what you like best about Miami Beach, Monte Carlo, and La Jolla.

Add to this agreeable physical setting something that sounds almost unbelievable: *no politics and no taxes.* [*Turn page*]

By J. J. Markey, M.D.

HANDITIP

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Ever found yourself minus your car key? Now on the market is a tiny, magnetized metal box for your spare key. Stick it, out of sight, to the underside of your radiator grille and find new peace for an absent mind. At most auto supply stores, $1 or less.

Any doctor licensed to practice medicine in the United States may practice in Tangier. You merely secure a certificate from a qualified home-state official, saying that you are licensed to practice there. This certificate is then endorsed by the State Department in Washington. It can be arranged by mail.

When you come to Tangier, you bring the certificate with you. It's presented to the administrator of the International Zone, who introduces you to the board of health.

At present there is only one American doctor in Tangier. The people like him. They would like to have a dozen more like him.

There are seven hospitals and six clinics, but inadequate laboratory facilities. Most of the doctors must do their own laboratory work. They all would like to see a young clinical pathologist with modern equipment come to town.

I asked Dr. Marquis R. Huffman, the sole American doctor, how long it would take a new man to get started. From one to two years, he thought.

"Two years," he said, "if he wanted to take it easy. One year if he got out and did a little promotion." He saw the look on my face, smiled, and said: "In Tangier, promotion is getting around, meeting the consulate people. Give a few speeches. Get your name in the paper. All the usual angles you would use in Lincoln, Nebraska, or Tacoma, Washington."

He thought that if a man had a couple of thousand dollars to tide himself over the first few months, he wouldn't have to knock himself out. "After all," he said, "that's the idea of coming to Tangier. To take it easy. To do just the type of work you want. And only as much of it as you want."

Doctors and consular secretaries were unanimous in declaring that their wives liked the life. "In the States," one wife told me, "I'd be doing my own house work. Here I have three servants. One of them is the best cook I've seen on land or sea. The whole bunch cost me a dollar a day and their food."

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ting in its own little park. But many families live as in New York or Paris—in apartments. These have from four to ten rooms each. Rents range from $30 per month in older apartments to $100 in the new luxury buildings.

A woman from California summed it up this way: "If you want to play it close to your vest, you can get by—servants and all—for one-fourth of what it would cost two people in Los Angeles. If you want to entertain a lot—really put on the dog—you can do it for about two-thirds of what a couple would spend in any American city."

Doctors from Tangier are often called as far away as Casablanca, in French Morocco, on consultations and even to treat patients. They make these trips quickly by air. French, Spanish, and Portuguese air lines maintain frequent service to all near-by coastal cities.

So many Europeans are pouring into Tangier each month to escape the impending Russian steamroller that real-estate speculation has become an exciting and profitable business. In spite of this, you can still buy or build a home for $10,000 that would cost $18,000 in California or New York.

It's a healthy place to live. Tap water is as pure as in any U.S. city. The beach is fifty miles long and a city block wide. Clean, white sand.

What more could a weary doctor ask? **END**

effective

in hypertension

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4. Yonkman, F.F.: Neurogenic Hypertension, Chemical Approaches to Its Amelioration, J. Michigan M. Soc. *50*:160 (Feb.) 1951.

A potent hypotensive principle biologically standardized in mammals

Veriloid is probably the most effective hypotensive agent available today.[1] Its characteristic effect, with careful administration, appears to be one of moderation rather than elimination of the hypertension.[2] The therapeutic ratio of Veriloid is relatively high, and long-continued treatment is possible because its administration does not produce idiosyncrasy or tolerance in most patients treated.[2,3,4]

In one study, the administration of Veriloid brought striking relief from hypertension and its disturbing discomforts in 80 per cent of patients with essential hypertension.[2] Veriloid controlled the blood pressure and produced a gratifying, beneficial effect, even after the failure of other hypotensive drugs in malignant hypertension in the preuremic stage and in hypertensive encephalopathy.[1,2] Veriloid has been found to control neurogenic hypertension, even after refractoriness to ganglionic blocking agents has developed.[4]

VERILOID

Clinical experience shows that Veriloid is effective in all forms of hypertension —mild, moderate and severe, and gratifying objective as well as subjective results follow its administration.

DOSAGE: The usual daily requirement of Veriloid is 9 to 15 mg., given in divided dosage three times daily, every 6 to 8 hours, the first dose to be taken after breakfast. The evening dose should be 1 or 2 mg. larger than the other two doses of the day. However, requirements for Veriloid vary from patient to patient, and in most individuals periodic adjustment in dosage is needed, because with continued administration patients become more reactive to Veriloid.

Veriloid is available in tablet sizes of 1, 2 and 3 mg., in bottles of 100, 500 and 1,000 tablets.

VERILOID-VPM

Containing Veriloid (2 mg.), phenobarbital (15 mg.), and mannitol hexanitrate (10 mg.), Veriloid-VPM provides valuable sedation and the vasodilating action of mannitol hexanitrate. This combination usually makes possible reduced dosage without sacrifice of therapeutic efficacy. Also, phenobarbital adds the advantage of increasing the spread between effective therapeutic dosage and the dosage at which side reactions occur.

VERILOID WITH PHENOBARBITAL

Veriloid With Phenobarbital (Veriloid, 2 mg., phenobarbital, 15 mg.) provides sedation without the action of mannitol hexanitrate. It is valuable when emotional tension must be controlled.

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Eight Steps in Hiring an Aide

Tested question forms plus system in looking boost the chances of finding a jewel

By N. W. Willis

• There are two ways to find a really able office aide. Either you wait for her to drop from heaven or you hunt for her in a raft of applicants. And hunting is the rule.

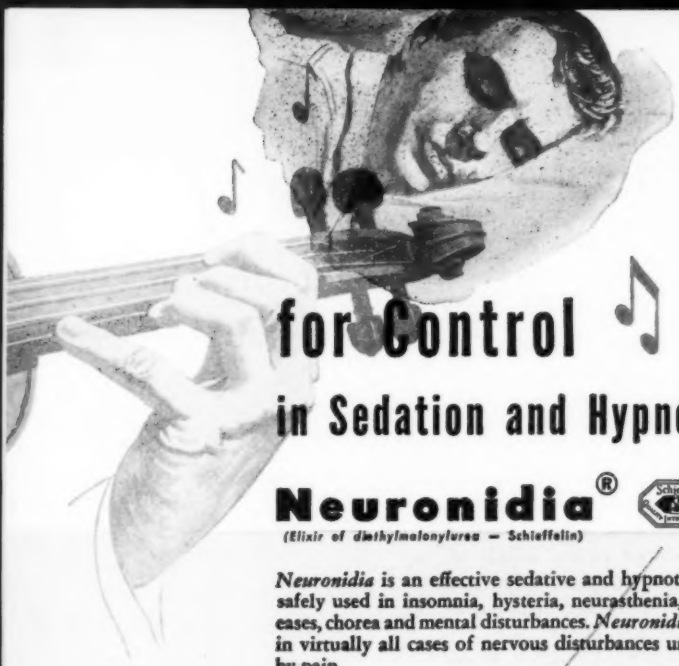
This time you're dead set on getting a paragon—one who'll train easily, and last. So instead of the usual hit-and-miss approach, try the systematic techniques developed by personnel experts. The materials you need—checklists, personal history forms, ability tests, etc.—can all be had at moderate cost from reputable consulting firms in this field.

One kit, available from The Personnel Institute, includes a detailed hiring handbook plus a supply of interview guides, personal history forms, and reference questionnaires. Cost: $17.50.

Using such hiring aids will enable you (a) to avoid the trouble and expense of experimenting with doubtful prospects and (b) to recognize your paragon when you see her. Here's how to go about it. Here, in eight steps, is the hiring design that personnel specialists recommend:

1. Describing the Job

No two doctors' aides do exactly the same work. Is *your* girl to be secretary, bookkeeper, office nurse, receptionist, lab technician, or one-woman combination of all of them? Think this question through. De-



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Neuronidia is an effective sedative and hypnotic. It may be safely used in insomnia, hysteria, neurasthenia, thyroid diseases, chorea and mental disturbances. *Neuronidia* is indicated in virtually all cases of nervous disturbances uncomplicated by pain.

Pharmacological and clinical research have demonstrated that the depth and degree of sedation and hypnosis can be readily controlled with barbital, the active ingredient of

NEURONIDIA

Neuronidia contains per teaspoonful:
0.13 Gm. diethylmalonylurea

Dosage: Orally, as a sedative
½ to 1 teaspoonful repeated as indicated
As a hypnotic
2 teaspoonfuls before retiring

℞ Sodium salicylate ʒIV
Neuronidia ʒIV

Sig: *To induce sleep and produce analgesia*
one dessertspoonful at bedtime.
For sedation and analgesia
One teaspoonful two or three times daily as required.

Supplied: Bottles of 8 fluid ounces, and 1 gallon

Professional samples and literature are available on request.

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cide exactly what you need. Then write out a complete *job description.*

Both the hiring handbook and your departing aide can help you with this. Just be sure the job description specifies fully the duties, the responsibilities, the hours, and the salary you can pay. If it does, it will simplify greatly your task of recruiting, interviewing, and breaking the new girl in.

2. Defining the Person

Now imagine that not impossible she who will fit your job. What age do you prefer? Married or single? Are you looking for an R. N. who's had medical secretarial training? Or a high school girl with typing and shorthand ability, whom you'll train yourself?

Using the hiring handbook to guide you again, you list the main characteristics you seek in your prospective aide. In other words, you write out your *person specifications.* These include physical aspects, education, experience, abilities, personality.

3. Recruiting

Once you have spelled out in detail the job to be filled and the type person you want, you're ready to throw out the dragnet.

In general, the more applicants, the better your chance of finding just what you want. Don't stint yourself as to sources of supply.

Enlist the help of your present staff, if any. Let your friends, colleagues, and medical society know you're in the market. From there spread the word to schools, professional associations, employment agencies. If necessary, place classified ads in newpapers and professional journals. R.N.'s can be located through nursing schools, local nurses' associations, and ads in nurses' publications. Many vocational schools and junior colleges train medical secretaries; their placement bureaus can give you leads.

4. The Screening Interview

This is a preliminary, ten-minute talk to weed out the clearly unfit and to record your first impression of the girls who may make the grade. As each applicant talks, you score her on personality, voice, poise, intelligence, self-confidence, education, ambition, ability to express herself, personal appearance. There's a special form for all this.

5. The Applicant's Story

For those few promising prospects who survive your initial screening, there's next a *personal history* form. This is filled out by the applicant at home or in your office. It's comprehensive, it's penetrating.

Questions on its six pages cover these biographical details: education, health record, employment, social and family history, financial status, and ambitions. It asks about things that *you* might hesitate to

bring up, or might not think of—giving you a wealth of facts to use in making your decision.

It shows, for example, whether the applicant has any major worries that might interfere with her work—worries caused, say, by being heavily in debt or by having a lot of dependents to support. It also gives evidence of whether she has the necessary incentive for your job, whether she's emotionally and vocationally stable, whether her personal background is satisfactory.

Of course, she'll put her best foot forward in her answers. But the questions are so numerous, so searching, so specific (and the answers lend themselves so readily to cross-checking) that you're pretty likely to get most of the information you need.

6. The Main Interview

Having picked the two or three likeliest girls, you call them in for a final interview. You tell them the nature of the job in detail, not forgetting its unpleasant aspects. You invite questions about it.

Then, using a *guided pattern interview* form, you get orally the chief details that were not covered in each applicant's written history or that need to be checked further. The aim is, of course, to get behind the "front" that applicants put up.

You ask such questions as: How did your previous employers treat you? What mistakes did you make in your work? What do you want to be doing ten years from now? What do you regard as your strong points? Your weak points? Why do you want this job?

How these questions are answered can be pretty revealing.

You ask *yourself* a few questions, too. For instance: Would we probably get along? Can she assume responsibility? Will she learn and grow?

This interview takes about half an hour. At the end, you explain to the girl that you will study her answers and let her know your decision soon.

7. Reference Checks

A third-person check on your own judgment is worth the small effort needed. Here, the trick is to get the truth. Seldom is a former employer willing to put the negative things about a person on paper. You may, therefore, have to ask some pointed questions by phone or, preferably, in person.

To help you in this instance there is a work reference investigation form. Sample questions, designed to ferret out facts, are: Why did she leave you? How did she get along with people? Would you take her back?

8. Aptitude Testing

Any job applicant who's still in the running now is likely to be a pretty good bet. You can take her on trial with assurance that she'll probably work out. [*Turn page*]

But suppose a doubt still remains in your mind? In that case, you may want her to take one or more aptitude tests. Such tests are commonly used to evaluate (1) mental ability, (2) clerical skill, (3) personality. (Tests for medical technicians are not generally available yet.)

Packaged tests for mental ability and clerical skills can be bought by mail; and the employer does the scoring. Personality tests, however, are given by, and scored by, the psychological staffs of personnel consulting forms.

The packaged tests are available from The Personnel Institute, already mentioned, and from The Psychological Corporation. For other sources, consult the psychology department of your nearest college. END

Head Hunter

• The exotic, turbaned head in the shop window caught his eye at once as a fascinating desk ornament. But the little Ann Arbor, (Mich.) store was closed for the week-end. By the time Dr. Edwin J. Hammer, of Grosse Pointe, could return for his prize, it was gone.

That was in 1935. Today, perhaps prompted by the frustration of his first rapture over a South Seas wood-sculpture, he owns what is said to be the largest private collection of Balinese carved heads in the U.S.

"Of course, I've never been quite able to duplicate the one that got away," he says. "And I never will. Even though several native craftsmen may work from

FOR RAPID...SAFE...PHYSIOLOGIC CONTROL OF FUNCTIONAL VOMITING

EMETROL®

PHOSPHORATED CARBOHYDRATE SOLUTION

- before and after anesthesia
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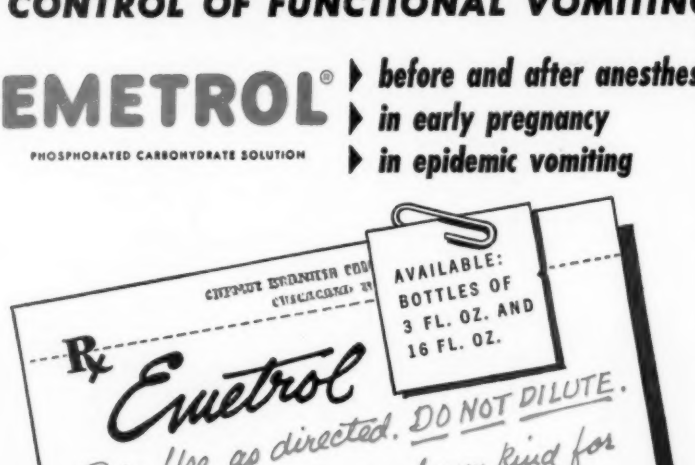

EMETROL is a phosphorated carbohydrate solution which controls functional vomiting through a unique physiologic action. Clinical findings have established its broad therapeutic effectiveness.[1]

Since EMETROL is free of antihistamines, barbiturates, narcotics, or stimulants, it may be prescribed for patients of all age groups with complete safety. Its delicious "peppermint candy" taste makes every dose welcome to the patient.

	INFANTS AND CHILDREN	ADULTS
Before and after anesthesia	1-3 teaspoonfuls 15-30 minutes before anesthesia and as soon as feasible after operation	1 or 2 tablespoonfuls at same intervals as for children
Early pregnancy		1 or 2 tablespoonfuls on arising, repeated every three hours or whenever nausea threatens
Epidemic vomiting	1 or 2 teaspoonfuls at 15-minute intervals until vomiting ceases	1 or 2 tablespoonfuls at 15-minute intervals until vomiting ceases

1. Bradley, J. E., et al.: J. Pediat. 38: 43 (Jan.) 1951

LITERATURE AND SAMPLES TO PHYSICIANS ON REQUEST

Kinney®

KINNEY & COMPANY, *Prescription Products,* COLUMBUS, INDIANA

the same living model, each supplies his own interpretation of expression and mood."

The thirty-eight heads he's accumulated in sixteen years are fashioned from satinwood, jack fruit, or sawa. They're pumiced and oiled to a high patina, and they range in color from onyx to ivory. Whether they qualify as fine art he doesn't know or care. The 42-year-old surgeon admires them chiefly for their anatomical perfection.

Among his favorites are Dewi Sra, Mpu Gandring, and Gusti Alit Oka—busts so named from the Balinese models who posed for them. The doctor has been able to identify many of his pieces through portrait photos in artist Miguel Covarrubias' "Island of Bali" and with the help of a friend who has spent some time on the isle.

Dr. Hammer hopes some day to visit Bali himself. Meanwhile he spends hundreds of hours annually in domestic head-hunting, writing letters, and scouring curio and art shops on all vacation and convention trips.

"I've generally made my luckiest finds in out-of-the-way places," he says. "Take the beautiful Legong dancing girl I picked up in a Mackinac Island store that specializes in Indian handicraft. Because this Balinese head didn't fit in with the rest of his stock, the proprietor let me have it for $18."

On average, the doctor pays about $40 for a head. Cost of his collection so far: about $1,500. He's never sold any heads and he doesn't intend to.

"There've been disappointments along with the triumphs," he reports. "Recently a woman with a mysterious manner and an Oriental sounding accent phoned to say she had a large Balinese head I could have for the cost of the postage, if I wanted it; it had only brought her ill luck. Delighted, I told her to send it along. But my suspicions were aroused when it arrived and the postage due was only 56 cents.

"Sure enough, it proved the cheapest kind of plaster of paris imitation, grotesque beyond words. I gave it to my youngsters, who have found an excellent use for it. It's out in the back yard, serving as an air-rifle target." END

"Well, see you next season—you old scalawag!"

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COD LIVER OIL *that makes*

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Desitin Hemorrhoidal Suppositories *with* Cod Liver Oil *help to* . . . **relieve pain and itching • minimize bleeding • alleviate congestion • guard against trauma** **promote healing** by virtue of their contents of high grade crude Norwegian cod liver oil, rich in vitamins A and D and unsaturated fatty acids (in proper ratio for maximum efficacy).

for greater patient comfort, *prescribe Desitin Hemorrhoidal Suppositories in hemorrhoids (non-surgical), pruritus ani, uncomplicated cryptitis, papillitis, and proctitis.*

℞ Composition: crude Norwegian cod liver oil, lanolin, zinc oxide, bismuth subgallate, balsam peru, cocoa butter base. No narcotic or anesthetic drugs to mask rectal disease. Boxes of 12 foil-wrapped suppositories.

soothing • protective • lubricant

samples *available on request* **DESITIN CHEMICAL COMPANY**

70 Ship Street, Providence 2, R. I.

Do You Have an Income From Rent?

Then make the most of it by taking these tax-saving steps the Treasury allows

• Doctors who double as landlords may well have despaired of their dual role in the past few years. While rental income has remained more or less constant, material costs have soared. So have utility and insurance rates. And plumbers, carpenters, and sundry repairmen now charge about twice what physicians do for house calls.

But cheer up! There's good news tonight. Its source, of all places, is the Bureau of Internal Revenue. For the tax rules permit you to deduct most of your rising rental maintenance costs on your 1951 income tax return.

These deductions can thin out your tax burden considerably. The trick is to claim *every* allowable expense you incur in maintaining your rented-out property. The following items, for example, are all deductible:

¶ Utility costs—the amounts you pay for gas, electricity, water, telephone, heat, or other conveniences you provide under the rental agreement.

¶ Repair outlays—for such things as plastering, painting, plumbing, and all carpentry that cannot be classed as major improvements.

¶ Salaries you pay custodians and service men who care for the property. [*Turn page*]

By Alfred J. Cronin

The author is a member of the firm of Murphy, Lanier & Quinn, public accountants.

¶ Premiums paid on fire or liability insurance during the year.

¶ Taxes for water and land—but not special assessments for such things as new sidewalks or streets, designed to increase the value of the property.

(If you rent part of the house in which you live—say, one-half of a two-family house—then, of course, you can deduct only that portion of the operating expenses that applies directly to the rented part.)

Major Improvements

Major improvements usually are not deductible in one lump sum. But when the improvement is made for the benefit of a specific lessee, it may be deducted during the term of the lease. If, for example, an operatic tenor lives in a building you own, you may deduct the cost of soundproofing his practice room.

Otherwise, major improvements (like a new heating plant, or a complete redecorating job) must be prorated over the life of the property. Keep a record of all such improvements to verify later claims.

Usually the cost of major improvements is absorbed year by year by your deduction for depreciation. When making this deduction, remember to include depreciation on furniture and equipment that you furnish your tenant.

While you're examining possible deductions from your rental income, don't skip too quickly over the income figure itself. There's more to it than just your tenant's monthly check multiplied by twelve.

For example, if he pays you in advance for the months of October through March, you are required to declare the entire amount on your return for 1951—even though his check covers three months of 1952. Again, if you require payment of one month's advance rent, to be applied to the last month of his lease, this sum must also be reported for the year in which received.

Suppose your tenant wants to break his three-year lease before it expires. Suppose he pays you a bonus to cancel the contract. This too counts as rental income and must be reported as such.

What if you have a working arrangement with your tenant whereby he pays you only $30 monthly rent, but in addition sends a monthly check for $50 to your bank as payment on the mortgage? Your income is $80 per month, as far as the Internal Revenue Bureau is concerned. Whenever the lessee pays your taxes, insurance, or operating expenses, you include these payments as rental income as well as expenses.

But should he decide to equip the bathroom with a stall shower at his own expense, that's different. It's not part of your income, so you won't pay a tax on *that* improvement—at least until you sell the house, when it shows up as a capital gain. END

The *Gentarth* formula constitutes a new, direct approach for relief of pain and reduction of swelling and joint inflammation in rheumatoid arthritis. *Gentarth* is non-hormonal in action.

Sodium gentisate has been found to produce favorable results in both rheumatoid arthritis and acute rheumatic fever,[2] possibly because of its inhibiting effect on the hyaluronidase in synovial cavities.[3,4] Inclusion of salicylate, as in the *Gentarth* formula, provides additional analgesic action and enhances effectiveness.

Gentarth tablets also contain succinic acid to protect against increase in prothrombin time—a necessary precaution in prolonged salicylate therapy.

Serving the medical profession for nearly a third of a century

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Each tablet contains:

Sodium Gentisate	100 mg.
Raysal *(representing 43% Salicylic Acid and 3% Iodine in a Calcium-Sodium Phosphate buffer salt combination)*	325 mg.
Succinic Acid	130 mg.

Dosage: 2 to 4 tablets 3 or 4 times daily (after meals and before bedtime).

Supplied in bottles of 100, 500 and 1,000. Available through all ethical pharmacies.

1. *Boyd, L.J., Lombardi, A.A. and Svigals, C.: New York Med. College Bull., 13:91, 1950.*
2. *Meyer, K. and Ragan, C.: Mod. Concepts of Card. Disp., 17:2, 1948.*
3. *Quick, A.J.: J. Biol. Chem., 101:475, 1933.*
4. *Guerra, J.: J. Pharm. Exper. Ther., 87:1943, 1946.*

to restore the Arthritic patient to

pain-free activity

"The best results were obtained in patients . . . treated with sodium gentisate and salicylate"[1]

Tablets

GENTARTH

The original preparation containing sodium gentisate, an inhibitor of the spreading factor enzyme, hyaluronidase

Ready Answers on Health Insurance

Words and phrases to use in selling your patients on voluntary coverage

● A patient, out of breath, burst into his doctor's office not long ago and dumped four different health insurance contracts on his desk.

"Tell me quick, Doctor," he demanded. "Which one of these shall I buy? I've got to decide before noon or I'll lose a month's coverage."

The doctor who reported this incident was genuinely annoyed. "What am I supposed to be—a doctor of medicine or an insurance expert?" he asked.

His question highlights a situation that confronts a number of M.D.'s today.

With stepped-up campaigns for selling voluntary health insurance now under way in many parts of the U.S., patients are looking to their own physicians for such guidance. It's logical. To whom, if not the doctor, should the patient turn for advice on health problems? And in the layman's mind, buying health insurance *is* a health prob'em.

Busy or not, the doctor has got to be ready to answer his patients' questions about health insurance. More than that, he must *prompt* such questions. For if the specter of compulsory health insurance is to be banished from the American scene, the private physician must do part of the job by making prospects for the purchase of voluntary health insurance out of his own patients.

The rest of the job—closing the sale and getting the contract—is not the doctor's business. Blue Shield representatives and insurance agents get paid for doing that. But the M.D. *can* create confidence in voluntary health insurance by having the right answers to patients' questions about it.

Here are the questions that patients most commonly ask. Here, too, are some suggested answers. Note this point: The answers are not, and need not be, complete. They're intended to be just sufficient to put the patient on the right track.

Q. "What's the difference between Blue Cross and Blue Shield?"

A. "Blue Cross, which is sponsored by the hospitals, takes care of hospital bills. Blue Shield, which is sponsored by the doctors, helps to

By Justus J. Schifferes, Ph.D.

pay your physician or surgeon."

Q. "How do I enroll in a Blue Shield plan?"

A. "The best way is through a group, preferably where you (or your husband) work. Group premiums are lower than individual premiums. So why not talk to your boss or the personnel department at the place where you work?"

Q. "What does it cost to get voluntary health insurance coverage?"

A. "In most cases, it will cost you only a few cents a day—about the cost of a package of cigarettes—to get coverage through Blue Shield (where available) or through other voluntary health plans."

Q. "What do I get? What am I covered for?"

A. "It's what you *don't* get that really counts: You don't get any more big medical bills to worry about. You're buying freedom from a major source of worry; and the value of such a purchase can't always be figured in dollars and cents. You can be sure that if you get sick again, you won't have a big financial burden added to your sickness problem."

Q. "What contract should I take? What policy do you recommend?"

A. "Any good contract or policy. Take the one that best fits your and your family's needs. As a physician, I'm not prepared to recommend one company's contract against another. In the long run, you're probably best off with those policies, (like many Blue Shield contracts) that guarantee you medical *service* rather than those that pay you cash to pay your medical bills.

"Don't forget, though, that the value of any insurance policy depends on the *attitude* of the company or plan about adjusting your claims against it. Some organizations tend to be more liberal in settling claims than others. A concern that charges very low premiums may be able to do so only because it throws out many claims for service or indemnity, on the basis of fine-print technicalities.

"If you get your health insurance coverage at the place you work, you can be reasonably sure you're getting a square deal. Your boss and his lawyer and the personnel and medical departments will have already gone through the fine print."

What Not to Do

Here are some things *not* to do when you answer patients' questions about health insurance:

Don't recommend a specific policy or contract. Advise "any good policy." There's always a chance for later criticism by the patient if you're too specific. Misunderstandings about claim procedures are too easy ("But, Doctor, you said this policy covered everything!").

Don't sign up the patient for a policy. Here again, if the patient is for some reason dissatisfied, he may direct his resentment toward you.

Don't designate some of your patients as "preferred risks" for volun-

sycosis barbae

Vioform
CREAM

10 out of 12 patients in one series[1]
22 out of 30 patients in another series[2]
responded to Vioform in sycosis barbae
after penicillin had failed.[1,2]

1. Martin-Scott, I.: Brit. Med. J., 1:837, *1949.*
2. Overton, J.: Brit. Med. J., 1:840, *1949.*

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VIOFORM® (IODOCHLORHYDROXYQUINOLINE)

Ciba PHARMACEUTICAL PRODUCTS, INC., SUMMIT, N. J.

Protein "Pick-me-up" in Pregnancy

an appetizing method of supplying the additional protein needed . . .

In pregnancy, especially during the last trimester, a protein intake of at least 85 to 100 Gm. daily has been recommended.*

To supply high protein intake *without bulk* — in a pleasantly palatable food or drink — Essenamine may be incorporated in meat loaves, baked goods, milk, fruit juices. The granules may also be taken as is or with milk, cream and sugar.

Essenamine contains three to five times as much protein as meat.

Essenamine "Pick-me-up" **— the following eggnog recipe (just one of many in the Essenamine recipe book) supplies 60.8 Gm. of protein in an appetizing beverage:**

Eggs	2	Combine all ingredients and whip in mechanical mixer or with egg beater.
Essenamine	4 tablespoonfuls	
Sugar	2 tablespoonfuls	
Vanilla extr.	Few drops	
Milk	2 cups	

Essenamine® COMPOUND

PROTEIN CONCENTRATE FOR ORAL USE

Supplied in three forms:

Essenamine Powder (unflavored),
7½ and 14 oz. glass jars.

Essenamine Compound Powder (vanillin flavor),
7½ oz. glass jars.

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7½ oz. glass jars.

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*Guerriero, W.F.: Texas State Jour. Med., 43:274, May, 1949.

Winthrop Stearns Inc.
New York, N. Y. Windsor, Ont.

tary health contracts. If you do, those whom you can't in good conscience recommend may put you on the spot ("But Doctor, you okayed Mrs. Jones for a policy. Why not me?").

Don't argue the general merits of voluntary health insurance. Simply stress its benefits to the *patient.* Anything more is apt to be a waste of time.

Equipped with thought-out-in-advance answers to patients' questions, you are now ready to work them into the conversation. There are two golden moments: (1) at the beginning of a consultation, and (2) at the very end.

Many Blue Shield and some other voluntary health insurance contracts *require* that the patient inform the doctor of his membership at the time of service. It's logical, therefore, to ask him right off; "Are you a member of Blue Shield?" or "Do you carry any health insurance?" A "yes" answer requires only a word of encouragement from you.

But if the patient says, "No. What is it? How do I join?" (or asks any of the other common questions) you can profitably spare a few minutes then and there to give him an interest-provoking answer.

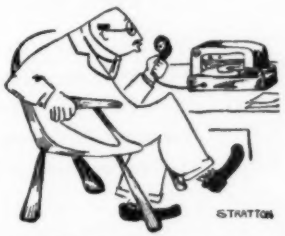
Many doctors prefer to talk up health insurance just before dismissing the patient. There are several ways of handling this opportunity. One practitioner we know says, "Sit down a minute, Mr. Harding. I want to ask you a question. Do you carry any health insurance? Do they have a Blue Shield plan where you work?"

Another doctor handles it like this: He hands his patient a booklet, pamphlet, or other literature supplied to him free of charge by Blue Shield. Then he asks, "Have you seen this? Do you know about this?"

A "no" answer is the opening wedge for the educational process. Patients *will* ask questions about voluntary health insurance if you introduce the subject and indicate that you are ready with the answers.

The demand for such insurance today is often greater than the supply. Individuals and families want it but can't always get it at a price they think they can afford. So the problem is not only one of selling the product but also one of delivering it. Be sure you're able to tell your patients exactly *where* they can get it.

This is always a local question. It requires a local answer. At the close of your interview, give the pa-



"Pelvic examination reveals nothing exciting—er-r, correction: unusual—so . . ."

tient several local names, addresses, and telephone numbers to which he can apply for further information. Call attention to these same items on the printed literature you give him. You may end your conversation like this:

"Show these to your boss or personnel director. Suggest that he get these organizations to explain just how you people can obtain the benefits of voluntary health insurance . . . And when you join up, let me know, so that we can adjust our records accordingly."

"Tell your boss"—that's the key phrase in this whole business. Experience with Blue Cross and Blue Shield has shown that actuarially sound plans can be developed most cheaply and most effectively when enrollment is offered through employed groups. The employer is thus in a key position.

When you get an employer in your office, handle him accordingly. Stress the business advantages of introducing a good health insurance program in his organization: less absenteeism, lower labor turnover, higher morale, higher productivity. One doctor sums it up like this:

"I needn't tell *you* that worry makes for illness among your workers. Voluntary health insurance makes worry about medical bills *needless*. Insured workers are better workers. Why not look into this matter today? Here are some organizations that can give you further details."

If enough physicians will give patients to understand what's in it for them when they carry *voluntary* health insurance, the bugaboo of *compulsory* insurance can be laid. The point is to be ready with the right answers. END

Rapid Clinical Response

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MEANS EARLY RETURN TO NORMAL ACTIVITIES

Continuity of treatment with well-tolerated CHLOROMYCETIN produces a rapid clinical response in a wide variety of bacterial, viral, and rickettsial diseases. Convalescence is smooth, and an early return of the patient to his normal activities may be anticipated.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) *is supplied in the following forms:*

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PARKE, DAVIS & COMPANY

MEDICAMENTA VERA

Art for the Doctors

[*Continued from* 82]

illustrating problem myself and present it in my own way," he points out.

The signature, "F. Netter, M.D.," has not only made him famous and highly regarded in the medical world; it's earned him the means to maintain a twenty-seven-room mansion with swimming pool on Long Island's swank North Shore. There at "Folly Farm," where he does most of his drawing, Dr. Netter often puts in eighteen straight hours at his drawing board—then goes fishing in Long Island Sound.

Best known of his recent work are the full-color illustrations he's done for Sharpe & Dohme and for Ciba. The Ciba series, a ten-year project, now numbers over 1,000 Netter paintings, many of which (showing lungs, gastrointestinal tract, reproductive organs, etc.) were recently collected in a 222-page hard-cover atlas. Two similar collections covering the nervous system are now in the works. "You can draw nerves until you go crazy," says Netter, who believes that "drawing medical pictures is the hardest work there is."

Netter (now 44) started out as a non-medical artist, painting stage sets, cover girls, and calendars. He switched to medicine because wiser (and overly pessimistic) family heads thought there was no money in art. But while going through N.Y.U. medical school, he illustrated a text on the abdominal cavity. And out in general practice, he found himself oftener at the drawing board than with his patients.

Finally he dispensed altogether with the latter. Anyway, he had married a classmate, Dr. Mary MacFadyen, who could uphold the clinical end. She did just that until finally distracted by the task of raising five Netter children.

During World War II, Dr. Netter headed the Army Medical Department's graphic training aids program. His best-known military work of art: the first-aid portfolio from which all combat troops learned what to do until the medics arrived.

What about the patient's role in medical art? Usually, of course, it's notably passive—but not always:

Interior Portrait

Illustrator Tom Jones tells about the time he drew a routine series of sketches during an abdominal operation on a European count. Later, the visiting nobleman happened to see the sketches. He promptly commissioned Jones to paint a full set in color. Presumably, these interior portraits now hang alongside the more conventional ones in the count's mansion.

Jones, a rangy 66-year-old Virginian, is the elder statesman of medical illustrators. He tumbled in-

to his career by accident in 1904. A railroad clerk and art student, he was asked to do microscopic drawings at St. Louis University School of Medicine. He liked the work and stayed on.

At the time, there were no medical art classes. Not till six years later did Max Broedel organize his first course at Johns Hopkins, where he eventually trained many of today's top artists. The second such school, at the University of Illinois College of Medicine, has been headed by Jones since 1925.

Jones is also medical art consultant to the U.S. Armed Forces, the V.A., and the Army Medical Library. He was first president of the Association of Medical Illustrators, organized in 1945 to boost the artists' professional standards.

Today, with dozens of textbooks and thousands of drawings to his credit, Jones spends most of his time teaching young artists and "exploring new visual education techniques in medicine."

Medical Sculptors

Increasingly popular among these techniques is moulage—lifelike models or casts of organic structures to demonstrate pathology, surgical methods, etc. And among artists specializing in this sort of work is a husband-wife team: Kenneth and Margaret Phillips, who do their medical sculpting at Scott and White Memorial Hospital in the mid-Texas town of Temple.

In building the fifteen or twenty wax models designed to show critical stages of an operation, Kenneth Phillips works hand in glove with the surgeon. The latter first details his operative plan; the sculptor then builds a master clay model of the incised area. From sketches made on trips to the operating room, he rebuilds the master model to represent each surgical step. Each time he makes a new mold from the model, then casts it in wax.

For their three-dimensional exhibits (often featured at medical meetings), the Phillipses work as a team. Kenneth designs, models, and casts; Margaret does the coloring and corrects flaws due to casting. Say the Phillipses of these major jobs:

"After we've spent six months on an exhibit and packed it off to the meeting, we heave a sigh: 'Well, we lived through another one. Guess we can get along with each other for one more year at least.'"

Actually, they've been getting along pretty well for more than twenty-five years. They met while taking Max Broedel's course at Johns Hopkins. Before that, Rochester-born Margaret had gravitated to the Mayo Art Studio as an apprentice, later went to Chicago's Art Institute. Her future partner had been infected with the medical art bug during his hospitalization as a wounded World War I veteran. He later developed his own talent by sketching autopsies in a Seattle

An Unusually Unresponsive Arthritis—Severely Painful, Recurrent . . . . .

Consider gouty diathesis as the cause. "Chronic gouty arthritis may be confused with osteoarthritis, post-gonorrheal rheumatoid arthritis and adult rheumatoid arthritis."[1]

Fortunately, there is a sure diagnostic test for gouty arthritis—gout should be suspected if "symptoms are *relieved* within 24 to 72 hours by adequate doses of *colchicine*."[2]

Specifically designed to meet the demands of gouty arthritis therapy—

CINBISAL *'McNeil'*
TRADE MARK

—provides colchicine (0.25 mg.) for its specific effect; sodium salicylate (0.3 Gm.) to combat pain in hyperuricemia; ascorbic acid (15 mg.) to replace vitamin C lost during salicylate therapy.

IN ACUTE CASES—medical management includes two tablets Cinbisal (equivalent to colchicine 0.5 mg. and sodium salicylate 0.6 Gm.) every hour until pain is relieved, unless gastrointestinal symptoms appear. (Eight to ten doses are usually sufficient.)

TO PREVENT RECURRING ATTACKS—one or two tablets every four hours.

CINBISAL *is supplied in bottles of 100 and 1000 tablets. (Engestic® coated green.) Samples on request.*

McNEIL LABORATORIES, INC. Philadelphia 32, Pa.

1. Comroe, B. I.: Arthritis and Allied Conditions, Philadelphia, Lea & Febiger, 1949, p. 734.
2. Ibid, p. 735.

morgue (courtesy of a friendly ambulance driver).

For most medical artists, life is as un-Bohemian as any doctor's. "The real drama in a medical illustrator's life is that staged in the operating room, under the hands of a fine surgeon." So says Ralph Sweet, once a protege of Dr. William J. Mayo, but now chairman of the medical illustration department at the University of California Medical School.

For a sample of such drama among the doctors, consider an experience that Kenneth Phillips recalls from his early days:

The scene was an operating room in a West Texas prairie town. On the operating table lay a big ranch woman undergoing a hysterectomy. Facing an audience of eleven tearful kinfolk were the surgeon and Phillips, bent over his sketching pad.

As the surgeon operated, he gave Phillips a play-by-play account of what to draw: "Now I'm tying off the blood vessels on one side of the womb; next, those on the other side." But at these graphic descriptions, the sisters, cousins, and aunts would break out in fresh wails.

Each time, as the lamentations rose to a nerve-racking pitch, the surgeon stopped operating, pulled off his gloves, and went over to the mourners. "Now, Bill," he'd say to the husband, "you know durn well everything's going to be all right. I'll have her womb out in no time. A few days and she'll be up and about."

"Thanks, Doc. The cows and chickens are sure missin' her."

Then the surgeon would slip on another gown, another pair of gloves, and return to the table. Throughout the operation, he kept up his running commentary aimed at the artist. Finally it was over—and when the last suture had been tied, the surgeon took off *five* operating gowns, accumulated from his sorties to quiet the relatives.

The operation was a success—medically and dramatically. And so were the Phillips drawings ("I got a check big enough to feed my family for six months," he says). For however unorthodox his theater of operation, here was a surgeon who knew how to work with his medical illustrator. END

Their OB Patients Go to School

These doctors have devised a course that helps mothers-to-be, saves their own time

• One of the most unusual guided tours in Manhattan takes place not in Chinatown or Radio City, but in Lenox Hill Hospital. There, every so often, about twenty healthy young women troop through in the tow of a white-clad medical figure. All of them (except the guide) are rather noticeably pregnant. They're sightseeing in the obstetrics department.

This prenatal trip to the scene of the birth climaxes a seven-class course that two enterprising OB men started a year ago for their private patients. It's an idea that could be put to good use by almost any doctor whose obstetrics practice forces him to double as a Quiz Kid.

Drs. George L. Bowen and Edward F. Stanton tried for years to answer every question of every primipara. But this educational procedure, they found, was unduly time-consuming. Finally their office aide, Rosemary B. Toth, R.N., came up with a solution. Both men were experienced medical-school teachers. Why not get their OB patients together and give them a course in the ABC's of planning for Junior?

The task of organizing these classes fell to Mrs. Toth. She began by studying the doctors' schedule. Both men were accustomed to seeing their prenatal patients at three-week intervals, on Mondays and Thursdays. So separate classes were arranged for each of those days. Time: the hour before appointments began. Place: the doctors' office.

Thus the two courses are concurrent and continuous, take eighteen weeks to complete. But new patients can start with any lecture in the cycle and still finish in time for delivery. There's no charge for the instruction. Attendance has averaged ten to twenty women per class.

Drs. Bowen and Stanton start off the lecture series. They explain anatomy, the process of conception, maternal and fetal changes. They answer questions—for example, why so many urine specimens are necessary; when to call the doctor during labor. By way of illustration, they use the standard anatomical teaching charts put out by the Maternity Center Association of New York. [*Turn page*]

By J. D. Oberrender

To aid skilled hands . . .

WELCH ALLYN OPHTHALMOSCOPE-OTOSCOPE SETS

Now available in No. 21 "Sandura" Cases for large or medium battery handles

Faster, more accurate diagnosis has made Welch Allyn ophthalmoscope-otoscope sets the world's most popular. The No. 983 set (above) is one of many combinations of ophthalmoscopes, otoscopes and battery handles to meet any physician's needs. All can be had in the attractive No. 21 case, far more compact, durable and sanitary than old style cases. Ask your Welch Allyn dealer to show you.

No. 216 operating otoscope. Rotatable holder for nylon specula gives greater operating space. Brilliant direct illumination.

No. 110 ophthalmoscope. Rotatable unit has standard, pin hole and slit apertures, white line grid and red free filter. Prefocused optical system.

WELCH ALLYN, INC., Auburn, N. Y.

The last five classes in the series are conducted by Mrs. Toth. They cover diet and exercise during pregnancy, layette essentials, formula making, bathing the baby, and finally the hospital trip.

Rustling up classroom equipment proved no problem for Mrs. Toth. "Several stores," she recalls, "sent us glossy prints of maternity fashions; we compiled them into a book which we keep in the waiting room. A leading department store gave us samples of maternity girdles and the like. Another provided a bathinette, still another a complete layette. The only cash outlay for the course, aside from the $2 spent for charts, has been $10 for a formula kit."

Among the expectant neophytes, the most popular class is the hospital visit. Their guide on this occasion is the obstetrical supervisor, who takes them to see the private and semi-private rooms, the nursery, the labor and delivery rooms, and introduces them to the nurses in charge.

From the doctors' point of view, is the course worth-while? The two OB men are convinced of it. "When these women learn exactly what to expect," says Dr. Bowen, "they become better patients. They give us much better cooperation. And the course actually saves us much question-answering time."

Can other physicians follow suit? Drs. Bowen and Stanton don't see why not. Hospital cooperation, they believe, can often be had for the asking. And if there's no R.N. aide on hand to help the doctor teach, he may be able to recruit a school nurse, a visiting nurse, or a housewife with a nursing degree. END

Specialism, It's Wonderful

• During my first weeks in private practice as an ophthalmologist, I expected—and got—many queries about that "big word." So I worked up a brief definition of my specialty that I was pretty proud of. Then one day a man came into the office and asked: "Say, Doctor, you're not an optometrist, are you? I mean, you do more than fit glasses, don't you?"

I thereupon went into my little spiel on the ophthalmologist and what he does. My visitor seemed much reassured.

"That's what I thought," he nodded, "but I wanted to make sure. You see, I'm quite worried about my little daughter. Her eye teeth haven't come through yet."

—DONALD G. NELSON, M.D.

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In developing Radelin Screens, the United States Radium Corporation decided not merely to provide *another* line of X-ray screens but a *better* line of screens. Recently completed scientific, impartial tests* of the Radelin Fluoroscopic Screen FG *prove* it affords greater brilliance than other fluoroscopic screens. Moreover, it provides good contrast, fine detail, and is long-lived.

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The significant characteristics of an X-ray screen are determined by the quality of its phosphor (fluorescent chemical). The United States Radium Corporation has been developing and manufacturing high-quality phosphors for a quarter century and is a leading supplier of phosphors to science and industry.

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Getting Along With Your Contractor

If you want a trouble-free building job, approach your construction boss this way

● When you're building a new home—or even just knocking out partitions and remodeling your old office—you become a layman among professionals. That's why it's generally safer to let an architect act for you in inviting bids, negotiating contracts, and supervising construction.

But perhaps you'd like to know exactly what's going on in your name. Or perhaps, with working plans and specifications in hand, you're devil-may-care enough to go ahead without benefit of architect. If the latter, watch for hidden rocks before diving in. Many an amateur builder has split his head on them.

The prime secret of success is to come up with a good general contractor—a man who knows his business and with whom you hit it off well. When an architect is your agent, the selection job is done through competitive bidding among competent home builders and general contractors known to him. But when you're on your own, it's probably better to pick your man on the basis of recommendations. Reason: Few amateurs are qualified to judge competitive bids.

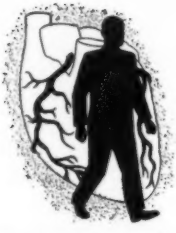
In fact, one building expert warns: "Don't shop around alone for contractors who'll build for less money. You may get caught by one who uses gyp methods."

Another expert adds: "The building contract is actually second in importance to your faith in the contractor."

How do you avoid fringe contractors and wind up with the right one? It's a little like the perennial question of patients—"How do I find a good doctor?" The answer in both cases: "Ask around."

Check with your savings and loan association, real estate board, local chapter of the National Association of Home Builders, or friends who have been through the mill. Usually each of these sources will yield several names. [*Turn page*]

For their aid in authenticating this article, MEDICAL ECONOMICS *extends its thanks to Edmund R. Purves, executive director, American Institute of Architects, and to Frank W. Cortright, executive vice president, National Association of Home Builders.*



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1 ***more rapid therapeutic response***
(therapeutic prothrombin level in 18-24 hours);

2 ***smooth, even maintenance of prothrombin level***
within therapeutic limits;

3 ***more rapid return to normal***
(24-48 hours) after cessation of administration.

In medical and surgical practice . . . as a prophylactic as well as a therapeutic agent . . . TROMEXAN extends the scope of anticoagulant treatment by reducing its hazards.

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Next step takes a bit of detective work. Starting at the top of your "recommended" list, ask the prospective builder about his business history. What buildings has he put up? What banks and mortgage firms does he deal with? What material dealers and subcontractors does he use? Ordinarily, he'll be glad to tell you.

If he has testimonial letters from these people, fine. But a phone call or two may give you a better line on the man and his work. Here are the points to investigate:

1. *His credit and finances.* In the ups and downs of the building cycle, a contractor who was in good financial shape last year may be on the rocks today. If you're in doubt, you can get his current rating from a credit agency. Cost: just a couple of dollars.

2. *His reputation for honest dealing.* Remember, the contractor is the one who hires and pays the workmen and subcontractors. He purchases all your building materials. Your local home builders association can give you a line on the man's reliability.

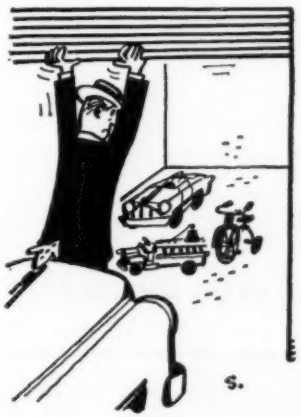
3. *His building know-how.* You need a man who's expert in every phase of construction work, from reading plans to mixing concrete. Check with some of the contractor's past customers. What bugs have developed in the houses he's built?

4. *His record in getting jobs done on schedule.*

Checking up on these matters will help you avoid the unhappy experience of a Middle West physician. He worked out all construction details with an alleged contractor, had his contract signed, sealed, and notarized. But one day, when he dropped by to watch his house going up, he found that all work had stopped. The contractor was gone.

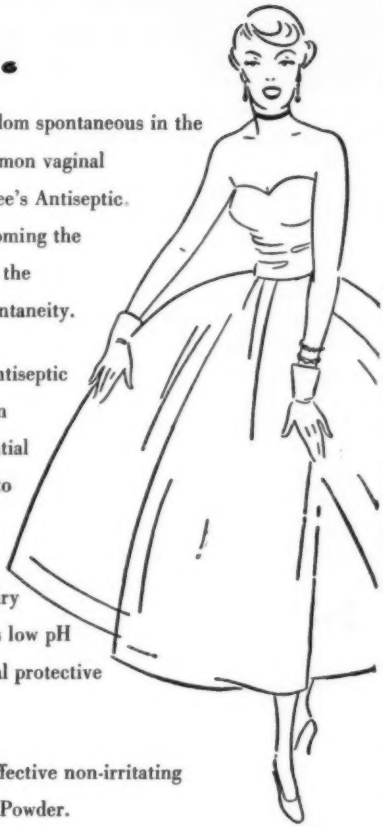
The luckless M.D. was quickly beset by unpaid laborers and suppliers looking for their money. He never did see the contractor again—nor the $1,200 he'd ill-advisedly advanced for materials and labor.

Once you've settled on a contractor, have him estimate the cost of your job. If his bid seems too high, you can check it by having your new home or office appraised in advance. The real estate board, a local bank, or the savings and loan asso-



Gaiety . . .

is seldom spontaneous in the woman distressed by one of the common vaginal infestations. For such a patient, Tyree's Antiseptic Powder has distinct value. By overcoming the offending pathology, it re-establishes the patient's normal enthusiasm and spontaneity.



The detergent action of Tyree's Antiseptic Powder assures thorough cleansing in routine hygiene and its cooling essential oils afford a soothing sense of relief to delicate membranes. In pathological conditions, this powerful but gentle antiseptic easily destroys most ordinary intruders. In either situation, Tyree's low pH helps restore and maintain the normal protective acidity of the healthy vagina.

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ciation will usually do this for around $25.

You may find that the contractor's estimate, although fair, is still too high for your inflation-battered budget. The only thing to do then is sit down with him and cut out some of the expensive non-essentials.

Most disputes between owner and contractor stem from misunderstandings over exactly what work is to be done. Hence it's vital that you thresh out the hundred and one details, then put them in writing. These agreements eventually become part of your building contract.

Contract forms to use as a guide can be purchased from your local bank or lending agency. The best contract forms, however, are those prepared by the American Institute of Architects, 1741 New York Ave., N.W., Washington 6, D.C. You can get them through your architect or by writing directly to the A.I.A.

Contract Contents

What goes into the contract? First, the plans and specifications. Try to detail all work to be done, from grading and excavating to the final coat of paint. Specify the materials to be used, too—your contractor is responsible only for the type of construction described in your agreement.

Next, decide on a plan for making partial payments as work progresses. If you're footing the bills with cash in the bank, the usual agreement is something like this: On the tenth of each month, you'll pay 85 per cent of the value of the work done and materials used to date.

When a banking institution finances your new office, payments are often made in three installments: (1) when the building is roughly enclosed and has a watertight roof; (2) when the plastering is completed; and (3) when the building is finally accepted.

Lump-Sum or Cost-Plus?

This payment method holds good whether the contractor has figured your job on a lump-sum or cost-plus basis. "Lump sum" means simply that he sets a fixed price that includes both his costs and his profit. "Cost plus" means that you pay him the actual cost of materials and labor, plus an agreed-on fee. This latter figure may be a percentage of cost—often 10 or 15 per cent.

The cost-plus method is usually acceptable when you're altering an old office. New ideas may pop up as you go along; key beams may turn out to be rotten, necessitating more extensive work than you expected. But if you sign a cost-plus contract, be sure the contractor agrees to *exclude* the following in computing his costs: phone bills, travel expenses, insurance costs, office maintenance, and the cost of poor work done over. These should all be considered part of his overhead. *[Turn page]*

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A.C.M.I. DIAGNOSTIC SETS

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Standard Set, Catalog No. 1106

STANDARD SET comprises ophthalmoscope head (with built-in color filter and aperture changer), otoscope head with 3 specula, medium battery handle and one spare lamp, in plush-lined case, with space for additional specula and tongue depressor.

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COMPACT SET, for the practicing physician, includes ophthalmoscope head (with built-in color filter and aperture changer), otoscope head, 5 ear and 1 nasal specula, small battery handle and extra lamp. Additional space for tongue depressor and more specula.

Large Set, Catalog No. 1109

LARGE SET contains otoscope head, 5 ear and 1 nasal specula, ophthalmoscope head (with built-in color filter and aperture changer), large battery handle, 1 extra lamp, with provision in case for tongue depressor head, additional specula and lamp replacement.

PROFESSIONAL SET. This, the most complete Wappler set, incorporates an otoscope head with 5 ear and 1 nasal specula, tongue depressor head, ophthalmoscope head (with built-in color filter and aperture changer), large battery handle, extra lamp, and rubber bulb for insufflation.

AMERICAN CYSTOSCOPE MAKERS, INC.

Frederick J. Wallace, President

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The lump-sum method, on the other hand, is generally more satisfactory if a new building is being erected. The architect's drawings make estimating safe enough for the contractor.

Another part of your agreement is the approximate date of completion. However, the contractor is not usually responsible for building delays beyond his control—such as those caused by fire, strikes, changes ordered, etc.

All the foregoing belongs in the "agreement section" of your contract. There's also a "general conditions section." Here you and your contractor define rights and responsibilities.

For example, the contractor will generally agree to:

¶ Maintain public liability and workmen's compensation insurance.

¶ Protect you from damages due to violations of building ordinances and laws.

¶ Pay social security and building materials taxes.

¶ Guarantee all work and make good all defects due to labor and materials for one year after acceptance.

¶ Leave building "broom clean," ready for you to move in.

For *your* part, you will generally be asked to agree to:

¶ Pay for fire insurance during construction.

¶ Provide an adequate survey of your property.

¶ Pay property tax (during construction, usually only on the land).

HANDITIP

Closet Cue

If you're tired of closet-groping at home or office, you can get a tricky little light for around $2.50 that fastens to the door jamb and goes on and off automatically with the opening and closing of the door. Twelve-foot cord plugs into nearest outlet.

What about building and utility permits? Your agreement here will depend on local building codes. Sometimes it's the owner, sometimes the contractor, who's required to take out these permits.

If your contractor fails to live up to any part of the bargain, you can cancel the contract—usually on ten to thirty days' notice. Of course he is also entitled to cancel.

You have two ways to protect yourself against your contractor's financial default. First, before you make each payment, require him to give you a waiver of lien. This is an affidavit certifying that all his bills for labor and materials have been paid to date. It protects you against later claims by the creditors concerned.

Second, you can require the contractor to sign a guaranty bond. In many communities, this is customary; it's always a desirable step if

you aren't quite sure of your man.

This type of surety is known as an owner's protective bond. It's included in the standard A.I.A. forms. It covers the contractor's performance of the contract (including your damage claims against him for avoidable delay in finishing) as well as all his financial obligations on your job. If you stipulate such a bond before bids are submitted, the contractor pays the premium; if afterwards, you pay it.

With this bond, if your contractor defaults, you're protected against suits for unpaid labor or material bills. What's more, if your office is still uncompleted, the surety company will see that it's finished for the balance of the contract price. Or, if you prefer, the company will pay you cash to finish it yourself. The "reasonable cost of completion" thus paid is determined by bids from three responsible contractors (picked by you, the architect, and the surety company).

Let's say your contract is all ready to sign. Go over it once more to see if *all* your questions are answered. For example:

Must the contractor keep building and cellar free from water? (In most cases, he'll agree to guarantee this for a year.)

Must you pay for work that has to be done over? (The contractor should agree to pay if the work is done incorrectly through his negligence or through his failure to follow plans and specifications.)

What trees and shrubs are to be protected during construction? (These must be specified in the contract.)

You may feel easier at this point if you have your lawyer go over the contract for omissions and ambiguous points. This is a good idea even if an architect has supervised the deal. Many architects advise it because of tricky variations in local building laws.

Contractor Takes Over

Once your copy of the signed contract is in your fist, you can relax—for a while. Your contractor then proceeds to award subcontracts for plumbing, heating, millwork, electrical work, and such. Many a contractor has no workmen of his own, but contracts separately for all such jobs, including excavating, masonry, carpentry, and painting. Like an orchestra conductor, he coordinates the efforts of the artisans who create your office.

Some owners, including doctors, have tried to take over this job. One such M.D. figured recently that *not* engaging a competent architect and contractor for his remodeling job had cost him about $3,000 extra. Nor did this figure reflect the time he was forced to spend getting materials and workmen together, settling disputes, and correcting mistakes of his own making. For all his frenzied supervision, his was a house that Jerry built.

No matter how carefully you plan

every detail, certain changes will occur to you during construction. These are extras; they cost extra money and cause more trouble than any other factor in building. The only sensible Rx: Try to think of all such changes *before* the contract is signed.

Getting along with your contractor can be a breeze if you follow these additional tips:

- Know exactly what you want to build, and have plans and specifications ready, *before* you call in the contractor.
- Arrange for permanent financing before construction begins. And don't forget a cash reserve to pay for possible changes in the plan.
- Don't keep your contractor waiting for payments. He has plenty of bills to pay for you.
- During construction, deal only with the boss—the contractor himself. Don't bother workmen or subcontractors with orders or complaints.
- Unless you know a good deal about building, don't try to supervise everything. That's what you're paying the architect or contractor for.

END

"For years I scrimped and sacrificed to send you through medical school. Now the first thing you tell me is to cut out drinking and smoking!"

More Than Corn Flakes

[*Continued from* 70]

sion. "Local doctors became acutely aware of this after attending the post-graduate courses we helped their county societies arrange. At the doctors' suggestion, we agreed to finance the needed equipment if they would bring into the area the right men to use it—qualified specialists in pathology and radiology."

Doctors Pitch In

Given this chance, the local physicians got busy. They enlisted the cooperation of hospital trustees and other public-spirited laymen.* Often it was necessary for several hospitals to club together in hiring the needed specialists, since it takes some 50,000 population to support a radiologist and about 100,000 for a pathologist. Arrangements were made for the men to ride circuit among a number of hospitals, spending one or two days a week at each.

"After the war," says Davis, "we carried the idea into Northern Michigan. At that time there was only one X-ray man in the entire region, and not a single pathologist. There was no tumor clinic, no deep therapy. A few small hospitals and a fair number of G.P.'s served the area; they weren't practicing modern medicine—and they knew it.

"Today it's a different story. The area now has nine radiologists, four pathologists. Two more of each are expected soon. Then every hospital in Northern Michigan, including the dozen or so that have gone up under the Hill-Burton Act, will have a consulting radiologist and pathologist. Altogether the foundation has helped set up diagnostic services in forty Michigan hospitals —twenty-four in the northern half of the state, sixteen in the southern. Nearly all Michigan hospitals now have proper diagnostic services."

Besides paying for the equipment, the foundation agreed to pick up the tab for any losses these services might incur during their first three years' operation. "But only one has been in the red since World War II," says Davis, "and then for only six months. All we've had to put up for operating deficits is $282."

No Failures

"Of course, we never step into one of these situations unless we feel reasonably sure the service will be able to carry itself—and within three to five years. So far we've had 100 per cent success. In another year or so we will have completely withdrawn our backing from all such services in Michigan. Our job here is about over."

The foundation has often discovered that local doctors needed

*See "Diagnostic Services for Small Towns," May 1950 MEDICAL ECONOMICS.

refresher instruction in how to make the most of their new service once it got going. In these cases it promptly packed them off at its own expense for four-day courses at the University of Michigan.

Where next? Today the Kellogg formula is beginning to be applied in Illinois, Minnesota, Colorado, Mississippi, Tennessee, Virginia, Alabama, and Georgia. But the foundation is no longer offering to donate equipment or defray losses. From its Michigan experience, it has decided that organization and initiative are more important than direct grants.

What it's sponsoring now is a body of organizers to circulate among small hospitals in these states to sell them on the advantages of pooling their efforts and resources to buy diagnostic equipment and retain the services of pathologists and radiologists.

The organizers work out of the state health departments, and Kellogg pays their salaries and expenses. It also gives each man a preliminary six-week course at the foundation, taking him around to study the services it has set up in Michigan. Before he moves on to the state where he's to take up his missionary work, an organizer is given a specially prepared map showing where in the state adequate diagnostic services are available and, more important, where they *aren't* and *should* be.

Says Davis: "We figure a pathologist or radiologist can't cover a hospital more than 50 miles from his home base. So we divide the state into medical service areas, each embracing the territory within 50 miles of a hospital.

"Take Tennessee, for example. It has twenty-two pathologists, all in four big cities. Its thirty-six radiologists are only a little less geographically concentrated. According to our map, the state needs fourteen more pathologists and twenty-six more X-ray men.

"Hard to find? Of course. But the medical men and hospitals of Michigan have been able to lure the specialists they needed, and so can other states—by the same means. These specialists, mostly fresh from their residencies came in response to medical journal ads, personal solicitation, and contacts made through the placement services of the American College of Radiology and the pathological specialty societies." [*Turn page*]

"That last X-ray made me feel so much better. Could I have another?"

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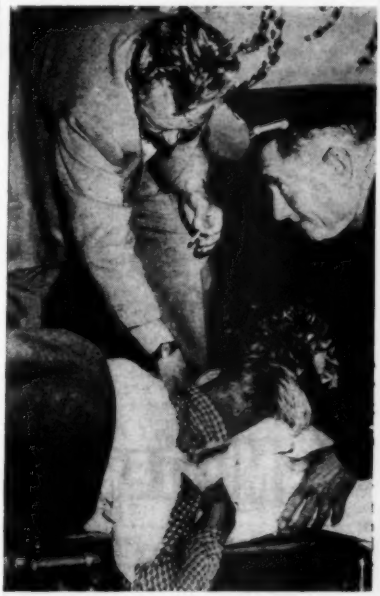
Graham Davis, silver-haired, bespectacled, and good-humored, got his start as an expert on hospital service with The Duke Endowment in his native North Carolina. His ideas today stem from his field experience there and in Michigan, and his chairmanship of the Commission on Hospital Care during World War II. This was the body, backed by the American Hospital Association, by the Public Health Service, and by Kellogg and a couple of other foundations, that came up with recommendations that served later as a blueprint for the Hill-Burton Act.

"One thing we learned at that time," he says, "is that the most effective way of organizing health services is on a regional basis corresponding to the local trading area. Society makes its living primarily by trade; so the hospital should plan its services accordingly, ignoring political boundaries.

"The major bottleneck in the evolution of the hospital as an effective health-service unit has been the manager. He should have enough ability and vision to carry this ambitious program to a successful conclusion. But management has not kept pace with medical science, which drives ahead rapidly. The average hospital manager has been called a 'glorified innkeeper,' and frequently with reason.

"I don't mean there are no able or aggressive ones; but their num-



Night Call brought a personal tragedy to Dr. Donald G. Tollefson, associate professor at University of Southern California medical school. Near his home, a boy had been pitched from a convertible when the door flew open on a curve. Routed from bed by police to aid the unknown victim, the Los Angeles physician felt in vain for a pulse beat. Then he discovered the dead youth was his own 18-year-old son.

bers are limited. In competing with business for brains, the hospital has fared badly. Trustees aren't willing to pay enough. Business learned long ago that the best brains are a good investment because they guarantee dividends. In this sense, lack of the profit motive among voluntary hospitals has been a severe handicap.

"Also, there's too much segmentation in the health field. A patient's medical problems aren't segmented. When he needs treatment he often doesn't know which segment to turn to. He wastes time and money trying to find out.

"Much more emphasis is needed on prevention than cure. The hospital is like the ambulance at the foot of the cliff; the public health department is the fence at the top. The major objective of the hospital should be to put itself out of busi-

"Heartburn."

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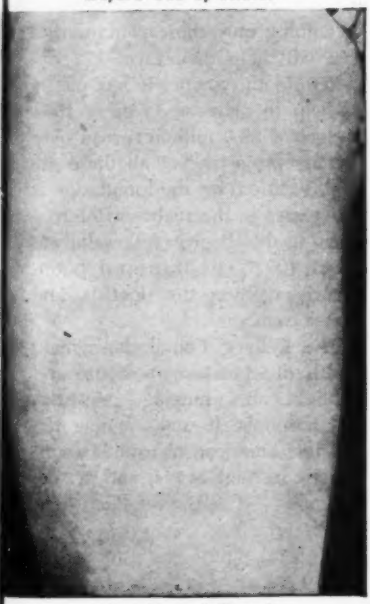

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RIASOL FOR PSORIASIS

ness. Yet the P.H.S., strangely enough, talks glibly about the huge numbers of additional beds the nation needs.

"We should expect better than that of an agency with such a fine record. But the voice of the empire-building bureaucrat now dominates it. In this and other respects we're suffering from the over-emphasis placed on security in a world that was apparently never meant to be completely secure. Too much security softens people and engenders an inferiority complex—the same complex that has messed up our international relations."

As a professional do-gooder, Graham Davis is cut from unusually tough-fibered cloth. He believes wholeheartedly in Kellogg's policy of helping only those communities that will help themselves.

Within this scope, it has plenty of help to give—based on a 1951 budget of $3.9 million spread over seventy projects. Not all these are in this nation, for the foundation is active also in the realm of international health. It gives fellowships to about 100 Canadian and Latin-American physicians, dentists, and nurses each year.

The Kellogg Foundation's main health divisions are medicine and public health, nursing, dentistry, and hospitals. It ranks among the first ten American charitable foundations in total assets, and is second only to the Rockefeller Foundation in what it spends to help the nation help itself to better health. END

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1. Smith, A. E., and Fischer, C. C.: The Use of Carob Flour in the Treatment of Diarrhea in Infants and Children, J. Ped. *35*:422 (Oct.) 1949.
2. Kaliski, S. R., and Mitchell, D. D.: Treatment of Diarrhea with Carob Flour, Texas State J. Med. *46*:675 (Sept.) 1950.

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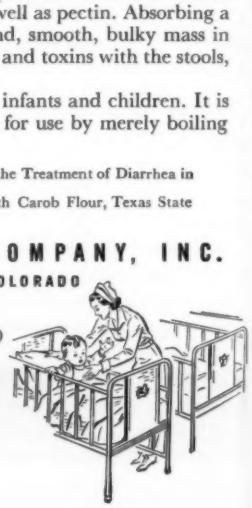

Where Britain's Planners Went Wrong

Their health policies have failed, says this noted English surgeon. There's a lesson for Americans in his commentary

By A. Lawrence Abel, M.S.

● As Britain enters the fourth year of the National Health Service, it may not be amiss to pause and ask ourselves if all is well with the medical care of the 50 million people who inhabit these islands. If we are to believe the many expressions of opinion that the working out of these plans has not been all that could be desired, we would do well to ask what have been the difficulties and how they might be put right.

In this connection, I suggest that we look at the plans which our profession has put forward during the last forty years, and compare them with the plans which the politicians have put into effect:

As far back as 1909, the British Medical Association evolved "A Scheme for a Public Medical Service." The following year it approved a draft scheme for the promotion of a national provident medical service. In 1911 Lloyd George introduced the National Health Insurance Bill, which led to the provision of a general practitioner service for the care of sick workers up to a certain income level.

In the years between wars, the British Medical Association and others published more plans for an improvement in the medical services for the nation. A B.M.A. committee in 1921 suggested the regionalization of hospitals and that advisory—not autocratic—bodies should be set up to correlate the work in each region. The B.M.A. published "An Outline of a National Maternity Service" in 1929, and in 1930 "A General Medical Service for the Nation."

The 1930 plan, incidentally, stressed that "the desire of even poor people to provide for themselves is a deeply rooted and laudable instinct which should always be encouraged." Today this is not

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The author, a distinguished surgeon, has long been a leading member of the British Medical Association. This article approximates his recent presidential address before the Metropolitan Counties Branch.

only being discouraged; it is being completely destroyed.

From 1931 to 1941 we published plans of "The Problem of the Outpatient," a revision of the "General Medical Service for the Nation," and dealt with "Industrial Health in Factories." In June 1941, the draft interim report of our Medical Planning Commission was published.

Through all these plans, emphasis was continually laid on the need for medical services to be evolved gradually, step by step, "by adaptation, augmentation, and reorientation of existing services"—for improvements to be brought in by evolution and not by revolution.

I have said enough to show that up to the middle of the last war it was we ourselves who made the plans; indeed, one might wonder if we have not been guilty of too much planning.

However, few if any outside the profession took any notice. It was only during and since the last war that the various Governments began to formulate bigger and bigger plans, entailing greater and greater control of medical services and medical personnel.

Down Their Throats

We can now ask ourselves: What are the differences between the evolutionary ideas of our own profession and the plans forced down our throats by the politicians?

First, the politicians demanded a medical Utopia overnight. Before the advent of the National Health Service, the profession was doing its best (and better than many other countries in the world) to meet the major needs of the population with the resources it had. It never claimed to do the impossible. But the politicians guaranteed to provide anything and everything for anybody and everybody.

They promised the earth, and cannot deliver it. Now that they have *proved* they are unable to give what they said they would, their policy has failed.

Secondly, I must remind you of some points in the philosophy of the "welfare state" which have been incorporated in the planning of the N.H.S.

Who Says It's Free?

For one thing, we must recognize that all politicians, of whatever shade of opinion, have promised "free" medical care for the whole nation. They took expert advice on what a comprehensive service would cost, and that advice (not obtained through the B.M.A.) was £200 million a year. We know that last year the cost of the service approached £500 million. So "free" medical treatment has become one of the most expensive items in the budget and a source of jeopardy to the national economy.

It has meant that the medical services, which were working very well before, now cost infinitely

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Pantothenic Acid	6 mg.
Vitamin B_{12}	20 mcg.
Folic Acid	3.6 mg.
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*MDR—Minimum Daily Requirement
†RDA—Recommended Daily Dietary Allowance

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more. The plans have gone seriously wrong.

Even today, after three years of the N.H.S., many people do not realize that their medical care is costing them far more than it did before. They do not realize that the service is only "free-at-the-time." They think that someone else is paying for it.

And many of them think that the whole of their insurance contribution is going towards the Health Service, whereas, in fact, the amount so going is only about 10d. a week. Less than 10 per cent of the total cost of the service is borne by this part of the contributions; over 90 per cent is borne by the taxpayer. This means that the sense of personal responsibility is being whittled away—a most serious thing for the spiritual and moral fiber of any nation.

Money Mystery

Another principle of the welfare state is that those in authority do not trust anyone to spend his own money. They therefore collect all, or nearly all of it, and spend it for him. This takes away from the individual a very large proportion of responsibility for what he does for himself.

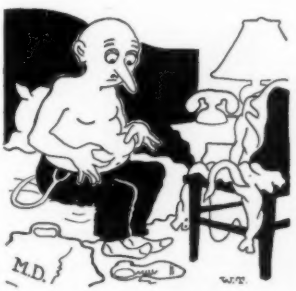
It is even almost impossible for him—until it is too late—to find out how his money is being spent. So he has lost his freedom of action, and has become a veritable slave of the bureaucracy.

This brings me to a third principle of the so-called welfare state—the need for control. I do not need to stress the hundred and one ways in which our lives—as well as our money—are today controlled.

I do not deny that a measure of control is desirable and necessary. In fact, our profession during the working of the N.H.I. recognized this need, and showed that we are not only prepared but anxious to control ourselves. But today, in contradistinction to being made to feel that we are partners and free laborers in the service of the sick, we are made to feel servile.

We may now consider what improvements, on the one hand, and what difficulties, on the other, have arisen as a result of the planning.

Every person, whether British or a foreign national in this country, has the right to the services of a family doctor, and this service is "free-at-the-time." A very large proportion of the public favor this system. However, there is much thoughtlessness and imprudent



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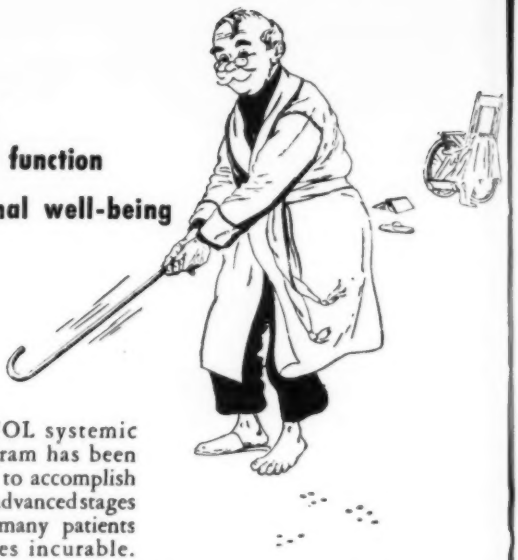

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Vitamin B_1	3 mg.
Vitamin B_2	2 mg.
Vitamin B_6	0.3 mg.
Niacinamide	15 mg.
Calcium Pantothenate	1 mg.
Mixed Tocopherols (Type IV)	4 mg.

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greed in the use of the service. The scramble for material benefits is partly responsible for the increased costs.

Another good thing which the plans were intended to bring about was that the doctors would have more time for the care of the health, in addition to the illnesses, of the people. It was hoped that the removal of a financial barrier would enable the doctor to see patients earlier in the course of their illness.

If, however, he is overworked, and required to carry out much non-clinical work in the way of certificates and form-filling, and if there are seldom opportunities for indulging in the real work for which he was trained, his clinical excellence will suffer. This is what has happened.

The plans envisaged that the doctor would be happy and not frustrated in his work; but in many instances this does not obtain. The plans were meant to make it easier for a young doctor to get into practice, and give him an easier time once established. In many cases this is not so.

Doctors Short-Changed

The planners promised that the doctors should be able to earn in the service the same (or greater) financial reward as they did before, with prewar values translated to the present day. All know what has happened to *that* plan. The plans included ample facilities both for post-graduate study and for relaxation; but in many instances this has not come about.

With regard to the hospital service, the repeated suggestions of the profession that hospitals should be grouped have been adopted. The state has assumed financial responsibility for seeing that hospital beds are where they are needed and that they are properly equipped. We have pressed for something like this for many years, and it is what the politicians guaranteed.

But those of you who have had experience with bureaucratic promises, whether oral or written, know what a difference exists between the promises and what actually comes about.

Today in many areas it is *more* difficult for a patient to get into hospital. In some places there are waiting-lists of from twelve to eighteen months. Great difficulty is often experienced in getting accommodation for an emergency, for the aged, and for the chronic sick. Although I say it is good for the state to assume financial responsibility, this is true only if the promises are fulfilled.

With regard to hospital finance, this now depends on public finance. During the first year of the service, the Minister ordered a 10 per cent cut in hospital expenditure. Recently he ordered a further 20 per cent cut in expendable hospital moneys. Someone must suffer—the patients or the doctors. [*Turn page*]

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Having considered some special examples of the effects of planning, let us now turn to some general observations.

The first was summed up by Dr. Wand (the general practitioner's great leader) a short time ago, when he said: "The Government plunged headlong, against our advice, into a comprehensive medical service." This is perhaps the most tragic aspect of the matter. Partly because of the bigness and partly because of the suddenness of the scheme, many pitfalls have arisen.

Economic Blackmail

It meant that many doctors entered the service because of the blackmail of economic pressure. It meant that many entered the service with ill will. Yet with tact, careful negotiation, and reasonable compromise, our help and goodwill would have been assured.

Space does not permit me to disclose to you all the pitfalls of gigantic planning. That suffering is often bound to occur, in order that a plan may be carried out, will be agreed by all. Sometimes it is the community that suffers, sometimes it is the doctor; but too often it is the one for whom the plan was meant to avoid suffering—the patient.

The bigger the plan, the greater the cost would appear to be, and the more impersonal. A large officialdom is out of touch with the individual workers. Although the officials are usually clever people on small matters, many of them are ignorant and hopeless in big matters. So we have come under the control of inexperts, and are subject to remote authority.

How can the plans be improved? First, we must ask another question: How is it possible to get back into the people a sense of moral responsibility for their medical care?

I believe the answer is that only by making a payment, if only a token payment, at the time of the receipt of the service will each individual be made to feel that he himself is responsible for its careful use.

But, you will say, we as professional men have always stipulated that there shall be no financial barrier between the patient and the treatment he needs. I agree. "Bar-

"Why, of course you are, by Gad! I'm going to get you well if it costs every cent you have!"

rier" is a strong word—it means an iron curtain; but "no financial barrier" does not mean that there should be no financial charge whatever.

How much, let us ask, constitutes a barrier? I am reminded that out of the weekly contribution to national insurance, the general practitioner receives less than 2½d. I am reminded that one cigarette costs a little more than 2d. The family doctor, therefore, out of your contribution receives the equivalent of one cigarette a week!

Would the equivalent of one or two cigarettes charged for the container of the medicine constitute a financial barrier? Would the equivalent of three or even six cigarettes constitute a financial barrier for a prescription, or for an X-ray examination?

Attlee Gives Ground

The Government recently announced, through no less a person than the Prime Minister, its acceptance of the policy that ls. should be charged for each prescription. Had it had the moral courage to implement that policy, there would have come about overnight a new sense of personal responsibility, a new awakening of moral integrity, a complete alteration in the economics of the service.

It would have proved a financial deterrent to any irresponsible or frivolous use of the service. It would have largely restored the independence of the doctors. It would have meant that each family took a more intelligent interest in its own minor ailments; it would have eased the heavy burdens of the family doctor, and given him more time to attend to matters of health in addition to those of sickness.

I am reminded of the Government doctor in Africa, inoculating the population against yellow fever. Although the service was free, and they were told it was free, each and every one insisted on paying his penny or twopence, in gratitude for the white man's magic. These men had enough sense of moral responsibility to feel unable to accept "something for nothing."

Cash on the Line

Now, what can be done to ensure that the people do not retain the idea that someone else is paying for them? The answer is, I believe, the same: that a token charge for many more details of the service should be made. At last the Government is making a token charge for teeth and spectacles. This principle should be extended.

A charge could be made for the container of the medicine, and a charge for the prescription. Similarly, there should be a token charge for an X-ray film, and a hotel-charge for a hospital bed.

There is some case to be made out for the individual doctor being allowed to charge a fee for the first consultation in any particular ill-

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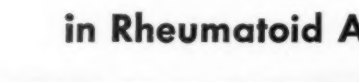

INCREASING supplies of CORTONE* now offer many physicians their first opportunity to prescribe this dramatically effective hormone.

Extensive evidence based on three years' clinical experience has shown that CORTONE controls both objective and subjective manifestations of rheumatoid arthritis in virtually all cases; in many of these patients, CORTONE has been used for prolonged periods of time.

It is reassuring to note also that the administration of CORTONE does not necessitate any measures that are not readily available to the physician in everyday practice. The use of simple laboratory tests, individualized adjustment of dosage, and careful clinical observation will permit most patients to benefit materially . . . without fear of undesired effects.

CORTONE PRODUCT FORMS:

ORAL—Cortone Acetate Tablets, 25 mg. each, bottles of 40 tablets.

PARENTERAL—Cortone Acetate, Saline Suspension for injection, vials of 20 cc., each cc. containing 25 mg.

TOPICAL—Cortone Acetate Ophthalmic Suspension 0.5%, 5 cc. vials.

Cortone Acetate Ophthalmic Suspension 2.5%, 5 cc. vials.

Cortone Acetate Ophthalmic Ointment 1.5%, 3.5 Gm. ophthalmic tubes.

Literature on Request

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ACETATE
(CORTISONE Acetate Merck)

ness. I realize the difficulties of this, and it might be better to have a small charge for each consultation. But if every general practitioner were allowed to charge the equivalent of less than thirty cigarettes for each first consultation, it would constitute a direct award for his work, would ease the load of the taxpayer, and the community would be protected against itself.

I am aware that there are those who declare it is immoral to receive a direct fee, and that all doctors should be dependent on the state. I maintain that the converse is true.

We, as doctors, are most concerned that a patient should have a direct, positive sense of his own responsibility. He must be interested in his own recovery, for without this he might as well spend the rest of his days in a Government hospital. An essential part, therefore, of therapeutic treatment is that it should include a token transaction.

What is required by Britain's specialists? They want to function as full partners in the hospital service, and not as subordinates. They see the hospitals being run more and more by salaried administrators, both lay and medical.

For ages, a spirit of partnership has existed between the lay and medical elements in hospital work. For many generations, hospitals have been founded, have been maintained, and have flourished in this spirit. Now we are faced with the growing danger that, instead of being partners, we may become subordinate employes.

Specialists in the hospital also want to have a much greater say in the choice of their own colleagues. The present methods of making medical staff appointments are most unsatisfactory. Except in some of the teaching hospitals, the medical staff now no longer have the official opportunity of recommending appointments to their board. Appointments are made on the recommendation of a mixed lay and medical committee, with a lay chairman, and with minimal representation of the senior staff, who often have not had the opportunity of even examining the applications.

The registrar problem went wrong because the Government formed its own ideas on a subject it knew nothing about, instead of be-

"Good news, dear. We won our case against that man whose car hit you."

ing guided by the profession. Its decisions earned widespread public derision. But still we have to fight to be continually consulted, and for the Government to accept our advice.

The consultants therefore want it agreed that regulations should be drawn up by the Ministry not only after *consultation* with the profession, but after *agreement* with it.

Save the Politicians!

If we set about the job of using our influence to promote the best for the health of our people, we shall be enabled to do the work for which we have been trained, free of the shackles of bureaucracy. We shall save the politicians from themselves, and our sons and successors from the politicians.

If the art, the science, the practice of medicine are to be crippled and stultified and frustrated by the baneful influence of elections, we are lost indeed. If the doctor, while he exposes his own body to the dangers and fatigues of hard and conscientious medical work, sees the very fountain of his strength becoming more and more blocked by corrupt regulations, he will cease to follow medicine as a vocation.

The Ministry may control his body by their regulations, but they cannot control his soul. They have not controlled the heroic ardor of our love for humanity, but the flesh is weak. Injustices are increasing, and cannot quickly be forgotten.

I have tried to show how wide of the mark are those who say the profession had no plans, and how much better our plans would have been. I have tried to show some of the disasters that have happened to medicine in the last three years—due, in my view, largely to the very vastness of the plans and the suddenness of their introduction.

I have suggested some remedies where things have gone wrong. I believe that a return of a sense of responsibility by the patient, and an increased responsibility by the doctors, are the master keys to the solution of many of our difficulties.

Let me close with some words of Abraham Lincoln:

"You cannot bring about prosperity by discouraging thrift.

"You cannot strengthen the weak by weakening the strong.

"You cannot help the wage-earner by pulling down the wage-payer.

"You cannot further the brotherhood of man by encouraging class hatred.

"You cannot help the poor by destroying the rich.

"You cannot establish sound security on borrowed money.

"You cannot keep out of trouble by spending more than you earn.

"You cannot build character and courage by taking away men's initiative and independence.

"You cannot help men permanently by doing for them what they could and should do for themselves." END

The Newsvane

P.G. Attendance Drops 30 Per Cent in Year

Medical educators are at a loss to explain the attendance drop at postgraduate and refresher courses reported recently by the A.M.A. Attendance at such courses during 1950-1951 fell almost 30 per cent from that of the preceding twelve months—even though the number of courses offered increased by more than 10 per cent.

Some doctors blame the drop on the increased number of colleagues entering military service. Others are more direct about it: Most postgraduate courses, they say, contain little of interest to the practicing physician.

Living Costs Outclimb Physicians' Fees

Physicians' fees have risen 45 per cent above their pre-World War II average, according to the U.S. Bureau of Labor Statistics. But in contrast, clothing costs have gone up 104 per cent; house furnishings, 113 per cent; and recreation, 68 per cent.

The over-all cost of medical care has risen 55 per cent since the 1935-1939 base period. That's less than any other major item in the family budget. A breakdown of the medical-care category shows hospital rates up 161 per cent, OB fees up 65 per cent, dentists' fees up 59 per cent, prescription-and-drug costs up 28 per cent.

Find V.A. Competing Unfairly with M.D.'s

Many a physician has leveled an "unfair competition" charge at the V.A. for its free-handed dispensing of medical care to veterans with non-service-connected disabilities. Recently the Erie County (Pa.) Medical Society came up with new facts to bolster the doctors' case.

Sixty-one of the first 270 veterans admitted to Erie's V.A. hospital, the society found, carried some form of voluntary health insurance. Of these sixty-one, only ten had service-connected disabilities "for which the Veterans Administration rightly assumes full responsibility." Twenty-seven non-service-connected patients—10 per cent of these first admissions—had insurance policies that would have covered both doctor and hospital bills in a private institution. Twenty-two other veterans had policies that would have paid for civilian hospitalization. [*Turn page*]

FOR WHOOPING COUGH

Inject

2.5cc Hypertussis

– the Dosage Concentrated to

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BABY PATIENTS

2.5cc Hypertussis®

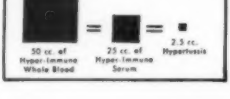
ELIMINATES THE HAZARDS OF MASSIVE REPEAT DOSAGE IN WHOOPING COUGH TREATMENT

2.5cc. Hypertussis is a specific answer to the treatment or passive prevention of whooping cough.

2.5cc. Hypertussis reduces dosage volume 75% . . . it contains the anti-pertussis gamma globulin equivalent of 25 cc. of human hyper-immune serum—a 10-fold concentration.

2.5cc. Hypertussis can be used concurrently with antibiotics, which are often indicated for secondary infections. Allergic reactions are rare with 2.5 cc. Hypertussis for it's concentrated from venous blood of *fasting* human donors.

2.5cc. Hypertussis is a crystal-clear homologous protein, ready for immediate intramuscular injection.



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BERKELEY, CALIFORNIA
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"A Thimbleful of Dosage for a Handful of Baby"

These insured patients, says the society, "should have had private medical care in civilian hospitals by civilian physicians . . . The physicians of Erie . . . strongly resent the unjust competition of a Government agency, supported principally by taxes, when it is a matter of rendering care to fellow citizens for non-service-connected ills."

Three Men Out of Four Don't Want to Retire

Are you looking forward to the day when you can snap down the cover of your sphygmomanometer and retire? If so, you may be surprised to learn that you're a member of the minority.

Only one man in four really wants to retire, says the Northwestern National Life Insurance Co. after surveying 3,000 of its male policyholders. In addition to the 24 per cent who look forward to a life of ease, 39 per cent hope to shift to lighter work some day. The remaining 37 per cent want to stay on the job as long as they can pull their weight.

'Ghost Surgery' Called A Growing Menace

"Ghost surgery" is throwing its shadow over more and more operating rooms, warns Dr. I. S. Ravdin, well-known Philadelphia surgeon. Here's how he describes the phantom practice:

Without telling the patient about it, the general practitioner hires a surgeon to do the operation. The surgeon has no part in deciding whether the operation is necessary; he doesn't even appear on the scene until the patient is under anesthesia. The patient never sees him, and is led to believe that his own doctor did the operation.

The insidious thing about this practice, Dr. Ravdin points out, is that "very soon the family doctor begins to do such procedures—not because he is competent to do them, but because the patient believes he is and a hospital permits him to operate."

Such behavior, asserts Dr. Ravdin, leads to the degradation of surgery: "It is fee-splitting in reverse. It is not only immoral; it is dishonest."

Hospitals Do Everything But Take In Washing

There's more than one way for hard-pressed hospitals to balance their books and counter the cries of "waste, inefficiency, and mismanagement." Many a hospital today is finding first aid in "fringe income." So reports George A. Hay, administrator of Woman's Medical College Hospital, Philadelphia.

Actually, as Mr. Hay points out in Hospital Management, "there is no such thing as fringe income. Any income dollar is as good as any other." [*Turn page*]

Some recommended sidelines for boosting hospital incomes:

¶ Sale of garbage, old paper, old records, empty flower vases, old X-ray films.

¶ Vending machines for cigarettes, soft drinks, nylons.

¶ Barbering and beauty service concessions.

¶ Radio and television rental concessions.

¶ Magazine stands run by hospital auxiliaries.

¶ Baby photography and sale of baby bracelets.

¶ Thrift shops, May fetes, and the like.

Among hospitals in the Philadelphia area, extra income from this type of effort now ranges from $10,000 to $60,000 a year. And, says Mr. Hay, that ain't hay!

Doctors Paying More Money to Aides

The salaries that physicians pay their aides are now two and a half times what they were in 1941. There's been a 10 per cent hike in the last year alone. These findings of Henry C. Black and Allison E. Skaggs, professional management consultants, are based on a ten-year survey of 300 medical practices.

In the offices surveyed, Black and Skaggs point out, "salaries paid to office assistants, secretaries, receptionists, nurses, and laboratory technicians . . . averaged $88.50 per month in 1941. Since then, the rates have increased to an average of $228.50 per month in 1951.

"The trend may well continue," the two consultants have reported to the Michigan State Medical Society. "In spite of this, we believe that capable, well-trained office assistants are still the biggest asset in any office and . . . are still worth all they receive."

C. Edgar Virden
Doctors rate second place.

Formula for Success: Put Patients First

"I never knew of a physician who failed because he put his patients' interest first and his own second."

Thus Dr. C. Edgar Virden, past president of the American College of Radiology, underscores his warning that doctor-patient relationships

Constipation

Turicum presents methylcellulose in its most efficient form—a hydrated gel—with magnesium hydroxide in less than laxative dosage to assure continued hydration of the gel throughout the intestinal tract.

In maintaining an osmotic equilibrium, the magnesium ion attracts and retains adequate water to keep the methylcellulose in the form of a soft gel—providing a distinctive, efficient **lubricoid** action which promotes gentle elimination.

EACH TABLESPOONFUL OF TURICUM CONTAINS:

Methylcellulose	0.3 Gm.
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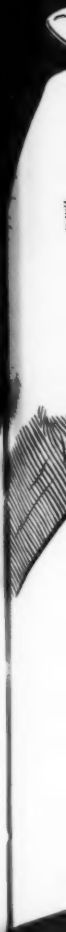

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. . . encourages normal evacuation
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. . . no interference with utilization of oil-soluble vitamin
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4. Better-tasting Heinz Baby Foods bear two famous seals—the 82-year-old 57 symbol of quality and the Seal of Acceptance of the American Medical Association's Council on Foods.

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"are too often neglected in the hurry and stress of our times."

"All too often," he adds, "our patients get the impression that they are of only secondary interest—that they are just another disease that has wandered into the office. This attitude does not win friends for us, and there will be many more times when we will probably need all the friends we can muster."

Teacher Shortage Looms For Medical Schools

With student enrollment at an all-time high, medical educators are concerned about a possible teaching shortage in a few years. They point out that the current tally of medical students—a whopping 26,191—is due to be surpassed as present schools expand and as new schools open. Yet as of June, 235 full-time teaching positions remained unfilled.

Twenty-Eight Dials Aid Diagnosis, He Says

It was an ingenious machine that Earl S. Laman, a chiropractor in Johnson City, N.Y., used to diagnose patients. He called it a "remodinagometer," and it had twenty-eight dials plus a dazzling assortment of colored lights. Its alleged purpose: to record a patient's "poison count" and to show "how much alive he was."

Law enforcement authorities proved somewhat less than dazzled. As they arrested Laman for the illegal practice of medicine, they got off a terse opinion: "Witchcraft at its lowest ebb!"

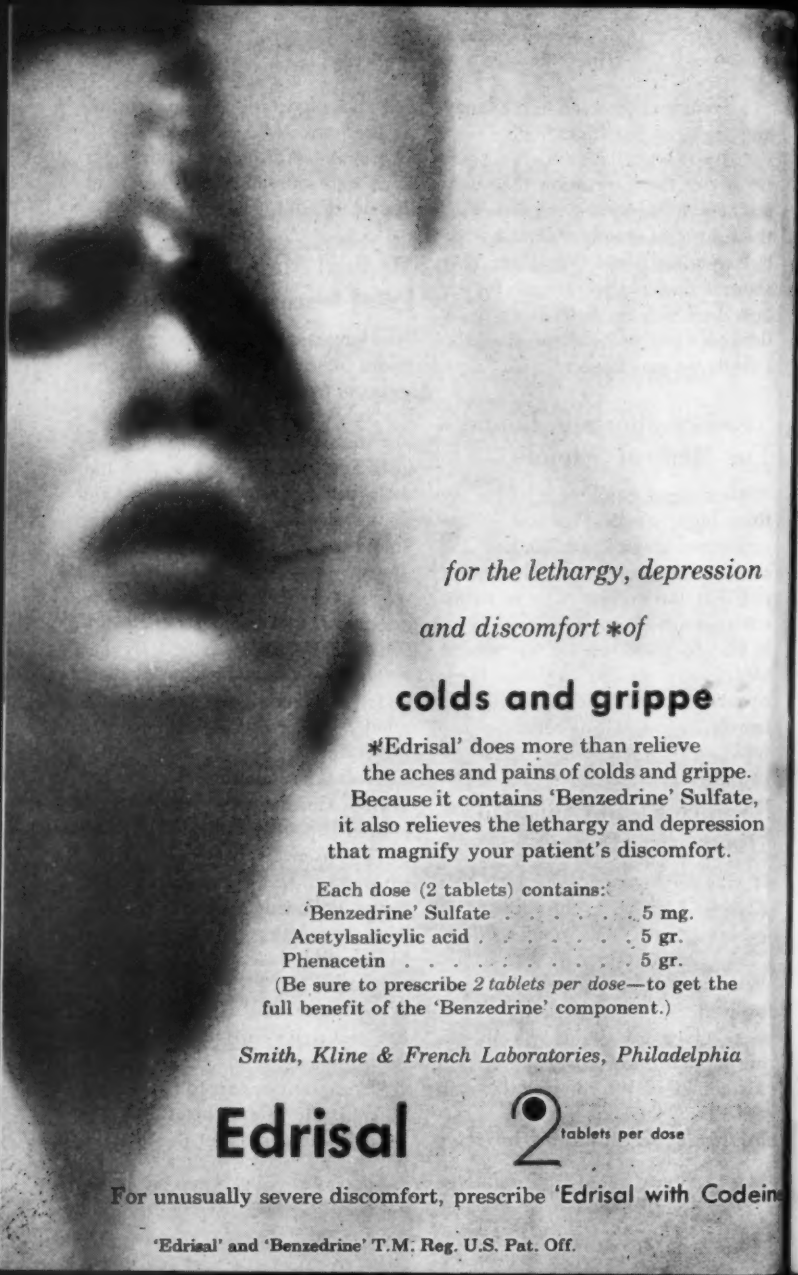
Medical Men Patch Up Feud With Druggists

The long-standing controversy between office-dispensing physicians and counter-prescribing pharmacists has subsided in at least one state. For the past two years, Iowa druggists and doctors have talked out their problems at thirty-one joint dinner meetings. Result: a remarkable degree of harmony between the two professions.

These local meetings, attended by state medical and pharmaceutical officials, are described by Dr. Fred Sternagel of the state medical society as "one of the finest public relations projects ever launched in this state."

Typical success story, as reported in American Druggist, centers around Spencer, Iowa. Here *all* M.D.'s used to dispense and *all* pharmacists used to counter-prescribe. Following the first physician-druggist meeting back in 1949, two M.D.'s sold their entire drug stock to pharmacists. Today all complaints about dispensing, counter-prescribing, and drug-substituting have been silenced.

The Spencer truce talks, like others in the state, encouraged the *druggists* to agree that they would:


for the lethargy, depression
*and discomfort *of*
colds and grippe
*'Edrisal' does more than relieve the aches and pains of colds and grippe. Because it contains 'Benzedrine' Sulfate, it also relieves the lethargy and depression that magnify your patient's discomfort.
Each dose (2 tablets) contains:
'Benzedrine' Sulfate . . . . . 5 mg.
Acetylsalicylic acid . . . . . 5 gr.
Phenacetin . . . . . 5 gr.
(Be sure to prescribe *2 tablets per dose*—to get the full benefit of the 'Benzedrine' component.)
Smith, Kline & French Laboratories, Philadelphia
Edrisal
2 tablets per dose
For unusually severe discomfort, prescribe 'Edrisal with Codein
'Edrisal' and 'Benzedrine' T.M. Reg. U.S. Pat. Off.

¶ Send customers to physicians whenever a prescription was in order.

¶ Take down all telephoned prescriptions in person, and check on refills.

¶ Arrange round-the-clock drug service.

¶ Stock drugs in the quantities desired by M.D.'s.

For their part, the *physicians* agreed that they would:

¶ Follow through with written confirmation of all phoned-in prescriptions.

¶ Use generic, not brand names for drugs.

¶ Write prescriptions for all patients requiring them.

¶ Discuss drug needs periodically with the pharmacists.

It's the beginning of the end of the pill-carrying physician, Dr. Sternagel proclaims. "Stocks have become so varied and large that no individual physician can afford to provide the large variety of tailored specifics for every emergency that may come up . . . Old-fashioned pill peddling is on the way out."

Got the Sniffles? Then Stay Out of Omaha

When Dr. Edwin D. Lyman took over as Omaha's acting health director, he promptly set about brushing up on the local health laws. Thumbing through one musty volume of statutes, he came across a lulu. It ruled that conductors on Omaha-bound trains must wire ahead if any passengers had head colds or other disease symptoms.

After pondering the problem of setting up a huge treatment center in Omaha's Union Pacific Station, Dr. Lyman conceded that the old ordinance probably wouldn't be enforced.

How Are Your Child-Bearing Habits?

A Baltimore radiologist is about to get started on a novel study of physicians' children. Armed with a Public Health Service research grant, Dr. Stanley H. Macht wants to find out (1) the prevalance of congential malformations among medical men's offspring, and (2) the effects radiation may have had on child-bearing. His studies will encompass 4,000 radiologists and 4,000 other physicians from coast to coast.

Helping Hand Extended To Medical Students

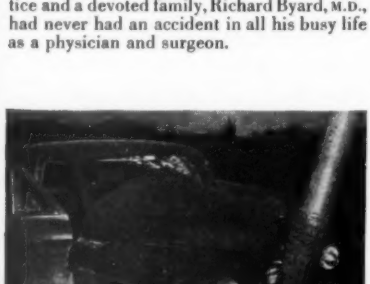
A loan fund for needy medical students has been set up by Wisconsin doctors. Their object: to attract young men who will later practice in the state's rural communities. Their goal: $250,000 in ready cash.

Preference in loans will be given to students at University of Wisconsin and Marquette University medical schools. "At least half the 600 students in these two schools could use some financial help," according

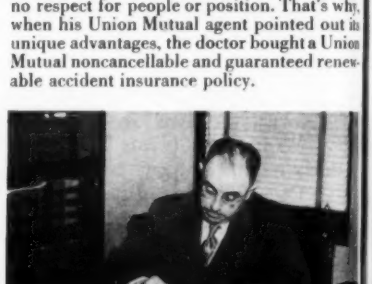
A True Story of* The Doctor who became the Patient

1. Happy and successful, with a good practice and a devoted family, Richard Byard, M.D., had never had an accident in all his busy life as a physician and surgeon.

2. But Dr. Byard knew that accidents have no respect for people or position. That's why, when his Union Mutual agent pointed out its unique advantages, the doctor bought a Union Mutual noncancellable and guaranteed renewable accident insurance policy.



3. On the evening of November 18, 1950, less than four months later, Dr. Byard was called from his home on an emergency case. His car left the road and he received severe injuries, including a broken hip and deep facial lacerations, that required immediate hospitalization.



4. Two days later Union Mutual's Claims Manager received notice of the accident. The claim was approved at once, and from the day of the accident Dr. Byard has received $200 each month. He will continue to receive this important financial help as long as he is totally disabled. He can also count on $100 a month for partial disability.

Moral: Professional men are wise to protect themselves against loss of income due to sickness or accident. They are *doubly wise* to make sure that such protective insurance is noncancellable and guaranteed renewable. Most insurance is not. Union Mutual's "noncan" is just what the name implies. You owe it to yourself and your family to get the true facts on this unique type of policy. Ask your local Union Mutual agent to tell you about it without obligation, or write to us for "The Whole Story", an informative folder written in clear, simple language.

*This true case history is typical of many thousand Union Mutual noncancellable insurance policyholders who know they can't buy better disability income protection.

For your own peace of mind . . .

Disability Income Protection

Underwritten by the UNION MUTUAL LIFE INSURANCE COMPANY

Agencies in principal cities • PORTLAND, MAINE

FOUNDED 1848

to Dr. W. D. Stovall of the state medical society. One-third of them, he adds, need complete support.

Are Prepayment Plans Unfair to G.P.'s?

Prepay plans don't cover enough office procedures—especially those done by rural practitioners. Nor do these plans give a fair shake to physicians who do the preliminary work on a case before referring it. Such flaws amount to discrimination against "the largest classification of physicians with whom Blue Shield does business."

These areas of G.P. discontent have been examined by Dr. John S. DeTar of the American Academy of General Practice. Writing in the academy's journal, he cites some cases in point.

Consider, for example, the Kentucky G.P. who "sends fewer than 100 patients annually to the nearest hospital, twenty-six miles away. His office [is] better equipped with X-ray and fluoroscope than the hospital." Yet for removing a large glass particle from the deltoid muscle, this G.P. received a mere $10 from the prepay plan. For the same service, the hospital would get $35.

The G.P.'s feeling that he is excluded from full participation in Blue Shield also becomes acute in referrals, adds Dr. DeTar. He cites an appendicitis case. The G.P. examines the patient, does a blood count, arranges for hospitalization —and receives no compensation whatever from Blue Shield. The surgeon gets $100 for performing the operation.

The G.P. can't even get an assistant's fee. "In many sections of the country," Dr. DeTar notes, "it is common practice for the referring physician to assist the surgeon. The great majority of Blue Shield plans, however, make no allowance for the assistant."

Every Fourth Taxpayer Makes a Mistake

For better or worse, one out of every four income tax returns contains appreciable errors. Some are honest mistakes, but many aren't. To snare the evaders, the Government this year will employ some 20,000 revenue agents and auditors and will spend over $100 million.

If your income is under $10,000, the chance that your return will be audited is about one in twelve. In the $10,000-$25,000 bracket, you have a one in six chance of getting double-checked. But if you earn more than $25,000, your return will positively get a going-over.

Most errors, not unexpectedly, favor the taxpayer. And the higher the income, the more frequent the errors. Common slips:

¶ One out of three taxpayers makes major mistakes in itemizing deductions—particularly medical expenses, charity contributions, and state taxes. [*Turn page*]

¶ One out of five of the moderate-income taxpayers makes exemption errors—usually by listing too many dependents. Some "dependents" may do double duty on several different returns. Children fail to grow up or long-buried aunts neglect to die—on certain individual tax returns.

¶ Unreported income is the favorite dodge of self-employed people, from doctors to bookies. Much of their income arrives in folding money that's hard to trace. But salaried taxpayers often fail to report dividends, interest, and rents.

To track down these income-reporting offenders is a major project of the Bureau of Internal Revenue. One way is to check a man's net worth. Thus the bureau finds out how, on a $6,000-a-year reported income, the person is managing to keep up with the $25,000-a-year Joneses.

Social Stigma Can Still Hamper Psychiatry

Dr. Francis J. Braceland, new psychiatrist-in-chief at Hartford's Institute of Living, thinks one of the biggest tasks facing medicine today is "to get rid of the social stigma that marks mental disease."

Too many American families, he says, "don't think of emotional illness the way they think when one of their kin enters a hospital with a broken leg. Instead, they still look askance at all psychiatric activities. We are engaged in a large campaign to dispel that feeling."

Dr. Braceland is well equipped for such a campaign. The psychiatric center he heads bears little resemblance to an institution. Thanks to its thirty-five acres of sprawling lawns and English village architecture—to say nothing of tennis courts, golf course, and swimming pool—some 350 patients get a pretty fair facsimile of country-club living.

There's heavy emphasis on "normal activities"—bridge parties, dances, concerts, and tours. The remaining time is devoted to doctors' appointments and study courses.

Francis J. Braceland
It's not like a broken leg.

Supervising the patients' rehabilitation is a huge staff of 600. Most

of them are the same people who, under the late Dr. C. Charles Burlingame, made the institute one of the country's most widely known.

Taxpayers Should Have Stood in 1913

Back in 1913, when Federal income taxes were born, a $10,000-a-year married man with two dependents paid Uncle Sam only $60. A Treasury Department table discussed recently in Congress shows how he's fared since then. For example:

1921	$ 526
1931	83
1941	1,117
1951	1,592

This tax phenomenon is even more apparent for upper-bracket gentry earning $25,000 and $50,000 annually. In 1913, such people (married, two dependents) paid $260 and $760 respectively. This year they'll owe $6,268 and $18,884.

Who says we don't work for the Government?

British Doctor Sings The N.H.S. Blues

The rumbling of discontent among Britain's panel physicians is a familiar noise by now. But Dr. A. Clein of Liverpool adds some vivid personal evidence of the G.P.'s financial fix. In a letter to the Medical World, he says:

"My income tax is unpaid; my car is falling to pieces; my house, policies—everything of value—is either pawned or mortgaged to the extent of its full market value. I am without not only a secretary, but also a maid. My wife now has to perform the duties of both without the slightest remuneration."

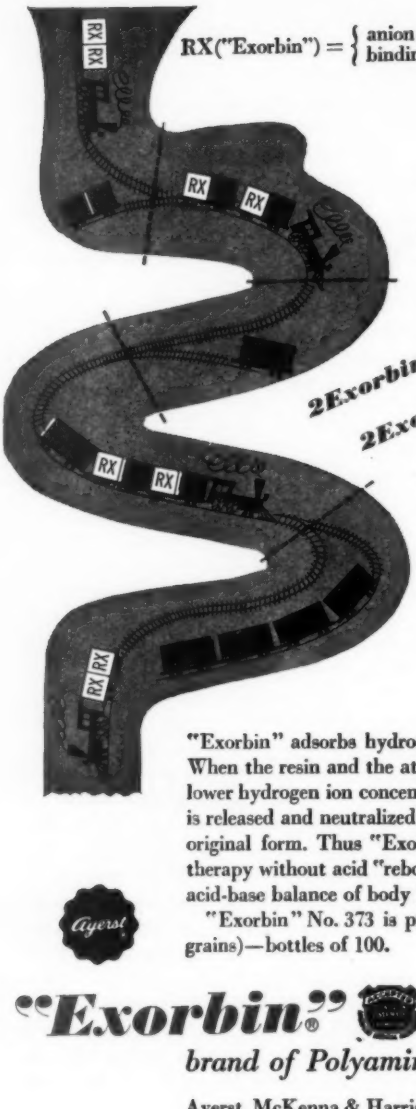
He doesn't see any end in sight. "Since the advent of the N.H.S.," he concludes gloomily, "the doctors will stand for anything."

M.D.'s Success Secret: Raise Large Family

Taylor Jackson, a Denver G.P., offers pretty convincing evidence that the rigors of supporting a large family needn't stop a man from becoming a successful physician. Dr. Jackson is the father of ten youngsters —seven of whom arrived before he first hung out his shingle. He claims there's nothing like having to buy shoes by the dozen to keep a man hustling through the lean early years of private practice.

Dr. Jackson drives an extra-roomy 1950 Hudson—the only model he found that would hold all his children at once. Only a few years ago, however, such a luxury was out of the question. Married during the depression, the Jacksons at first existed mainly on big dreams and odd jobs.

Taylor spent five years as a chemist before he entered medical school. Then, to keep food on the table, he took on an assortment of side jobs:



"Exorbin" adsorbs hydrochloric acid from gastric juice. When the resin and the attached acid molecules reach the lower hydrogen ion concentration of the intestine, the acid is released and neutralized; the resin is then excreted in its original form. Thus "Exorbin" provides effective antacid therapy without acid "rebound," without interference with acid-base balance of body fluids.

"Exorbin" No. 373 is presented in tablets, 0.25 Gm. (4 grains)—bottles of 100.

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as paper hanger, teacher, painter, carpenter, taxi driver, and blood donor. His wife helped out by running a day nursery and taking in boarders.

In 1946, Taylor Jackson moved into his first private office. Today he is well established—both professionally and as a community leader. But he doesn't let his outside interests get in the way of medicine. Last June, for example, he was supposed to address his church on "The Special Meaning of Father's Day." Half-way through the opening hymn, he excused himself and rushed off—to deliver his 508th baby.

Stretching his income ($9,000 net) to cover family needs is a problem, Dr. Jackson admits. A month's food bill comes to about $225; children's clothing sets him back about $700 a year. Sometimes, however, he's able to profit by the family's size. Witness these typical cheaper-by-the-dozen savings:

¶ Mrs. Jackson, who buys more milk than some of the local groceries, persuaded the milk company to sell to her at wholesale prices. Result: a $250-a-year saving.

¶ Although the Jackson children range from 2 to 14 years, even the youngest helps out around the house. So Dr. Jackson bought his home on a finish-it-yourself basis. He and his wife tackled big jobs like insulating the ceiling; the children did all the lathing.

¶ Last summer a Denver swimming-pool owner offered a special all-season rate of $25 "for the whole family." Recognizing a bargain when they saw one, the Jacksons managed a summer's fun for a little over $2 each—much to the pool owner's dismay.

In featuring the Jacksons as its "family of the month," the American Magazine recently explained why Taylor and Marjorie Jackson launched their ambitious child-raising program: "They were annoyed, in their campus courting days, by classroom talk to the effect that only 'poor, dumb people' have large families. They themselves came from large families and were proud of it. They resolved to prove, at least to themselves, that having a large family does not necessarily interfere with either schooling or family progress. Today they believe they *have* proved it."

Sickness Surveyors Are Having a Field Day

Three large-scale studies of U.S. health conditions and resources are currently being conducted by responsible private groups. That's one reason why the sickness survey proposed in S. 1328, up for discussion in the Senate, will probably never come off.

Here's how the studies shape up:

1. The Commission on Chronic Illness is studying the whole chronic disease field. Its survey covers "the extent of such diseases and the programs—Federal, state, and local—be-

ing conducted to meet their needs."

2. The Brookings Institution's study of U.S. health resources has been completed, is almost ready for publication.

3. A new commission to study hospital financing was established early this year. It has started a three-year survey that will touch on "the problem of chronic illness with special reference to hospitalization costs."

Medical Schools Getting More Money to Spend

After studying medical school finances as of 1947-1948, a Public Health Service committee last year issued a pessimistic report: "We estimate that the unmet needs [of our medical schools] could be financed only by the expenditure of about $40 million a year more than [they] are now spending . . ."

That dollar deficit has now been nearly obliterated, the A.M.A. asserts. During the current academic year, it reports, the medical schools can count on $36 million more in spending money than was available to them in 1947-1948. About three-fifths of the increase will go directly into the schools' operating funds (the other 40 per cent is earmarked specifically for research).

The added money for operating funds has come from two main sources: (1) state and city; (2) private. Since 1948, the thirty-eight schools supported by state or city taxes have had $13 million added to their operating budgets. During the same time, private grants to the forty-one schools that depend mainly on such grants for their operating budgets, have been increased by about $9 million.

Insurance No Protection Against Big Bills

Most health insurance plans offer poor protection against serious illness. That's the conclusion of a University of California research group after a two-year study. Its purpose: to assess the burden of medical bills on middle-income families.

During the two-year period, the Heller Committee for Research in Social Economics charted the medical expenses of selected wage earners in the San Francisco Bay area. The 455 households covered included 1,504 persons, or slightly more than three persons a family. Yearly income of the families surveyed averaged $4,142, with a range from $1,553 to $21,690.

Annual medical expenses averaged $240 per household, or about 6 per cent of total income. This percentage figure, the Heller committee comments, would not be too heavy a burden for any of the families. But statistical averages don't mean much when applied to sickness bills. Actually, some of the families surveyed spent less than 1 per cent and others up to 25 per cent for medical bills. A few un-

lucky ones were threatened with insolvency "for years to come."

Furthermore, medical expenses were often highest in the families that could least afford them. Reason: Lower-income families tended to be larger (usually four or five persons) than those in the higher-income brackets.

Present prepayment plans, the committee finds, either ignore catastrophic illness or provide reimbursements "that are insignificant in comparison with actual costs." These costs, it says, must be spread over a large part of the population—good and bad risks alike. The committee maintains that this can be done "within the framework of private medical practice."

The Family Physician Turns the Tables

During the early Twenties, the G.P. was everybody's All-American. Twenty-five years later, he was playing the position of Left Out: Medical schools were staffed almost wholly by specialists; post-graduate courses were planned for and given by specialists; medical papers were written for and by specialists.

Today? "There has been a noticeable change in this condition," says Dr. Jason P. Sanders, president of the American Academy of General Practice. "Medical schools are asking us what we think . . . and are planning courses to meet the general practitioner's needs. Many general practitioners are going back into teaching . . . [Others] are beginning to write articles for medical journals and periodicals."

Jason P. Sanders
No more playing Left Out.

The reason for this change? Dr. Sanders thinks the formation of the A.A.G.P. (in 1947) had a lot to do with it. The academy, he says, has helped bring about "the development of leadership again for the family doctors of America."

Atomic-Age Emporium Caters to M.D.'s

Dawn-of-new-era note: The nation's first atomic-age department store has opened in New York. It features across-the-counter sales of Geiger counters and other radiation instruments.

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Mitchel, scientist and store manager: "Already we've had all kinds of customers." Not the least of these is the medical man, who finds several A-gadgets designed just for him.

For example, there's a model called the Cutie Pie, designed for the research M.D. It measures alpha, beta, and gamma activity. For the radiologist, there's the pocket-size Minometer, shaped like a fountain pen. This one computes daily radiation intake. Other models: The Super-Sniffer for the uranium prospector; the Classmaster for the college professor; the Civion for civil defense workers.

How Field Workers Can Help Doctors

There's nothing like a field man for pumping new life into organized medicine's activities. Witness how Lawrence Rember got around in his first six months as director of field service for the A.M.A.:

Rember visited thirteen states and the District of Columbia, making twenty stops along the way. As follow-ups to his field work, he dispatched 106 letters, forty-four memos, and two lengthy reports. While on the road, he concentrated on discussing P.R. matters with doctors active in state and county societies. But he found time to do a lot more besides.

In one state, for example, he polled public opinion on attitudes toward medical men. Another time, he was called on to handle press relations at a state convention. Other odd jobs: addressing local medical society sessions; writing press releases; sounding out political bigwigs on medical matters; being interviewed himself by local reporters.

The significance of this new field-service approach? One man visited by Rember sums it up this way: "The A.M.A. is coming closer to the doctors, and the doctors are noticing it."

Unwise Talk Still Causes Most Malpractice Suits

Malpractice claims, which have increased tenfold in recent years, are still generated largely by "unwise comments or criticisms of physicians with regard to treatment given to patients by other physicians." So warns Dr. Louis J. Regan in a report to the A.M.A.'s Committee on Medicolegal Problems.

Not only are most of these claims without merit, reports Dr. Regan, but they could quite easily be avoided: "Various authorities have estimated that 50 to 80 per cent of all malpractice suits would be eliminated if such destructive criticism could be stopped."

A second source of malpractice suits is labeled simply "insufficient care." The West Coast physician lawyer cites some examples: "Failure to make a blood count, a Wassermann, a pregnancy test, a

ture, a smear, a urinalysis, a stool examination, an X-ray, original or follow-up; failure to make a complete diagnosis; failure to utilize an indicated prophylactic measure (diphtheria, tetanus, etc.); failure to give instructions, to follow up the original treatment or operation, to institute measures to protect contacts."

Malpractice suits "arise almost invariably out of the first course of treatment," Dr. Regan reports. They are rarely brought by old patients. What can the M.D. do to safeguard himself?

Some Regan suggestions:

¶ Keep "ideal" records in every case, showing clearly what was done. If any patient discontinues treatment before he should, or fails to follow directions, let the record show it. For example: "Whenever a patient refuses to have an X-ray made, the physician should fortify himself with the strongest written evidence."

¶ Use a consultant whenever indicated, particularly if the patient is not doing well or seems dissatisfied.

¶ Don't ever examine a female patient unless a third person is present. "There is no more serious or destructive charge than that of undue familiarity."

¶ Advise patients of any intended absence from practice and recommend (or, better yet, make available) a qualified substitute.

¶ Prepare the patient carefully for the probable results of treat-

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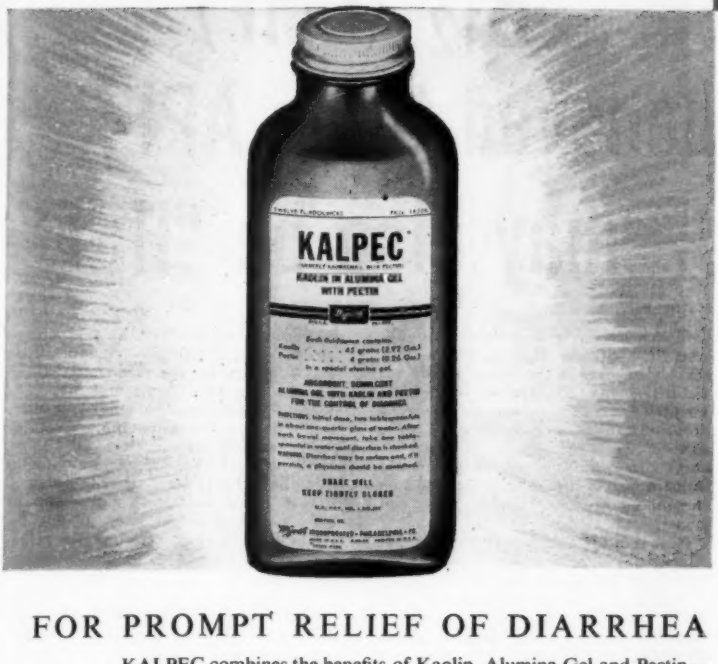

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DOSAGE IS SELF-LIMITING

Initial dose, 2 tablespoonfuls in about ¼ glass water, then 1 tablespoonful after each bowel movement until diarrhea is checked.

As diarrhea subsides, dosage is reduced—
When diarrhea is stopped, medication is discontinued.

If no satisfactory response is observed within 24 hours, resort to other measures should be considered.

Supplied: Bottles of 12 fl. oz.

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B_{12} (EMF) believed to be APF; may also be "HGF"

Evidence has been accumulated to suggest that vitamin B_{12}—now generally acknowledged to be the pure erythrocyte-maturing factor (*EMF*) or anti-pernicious-anemia (*APA*) factor—may well be identical with animal protein factor (*APF*). APF has been found to be essential for normal growth, and probably for the maintenance of life, in many animal species including chickens, pigs, rats, and mice.

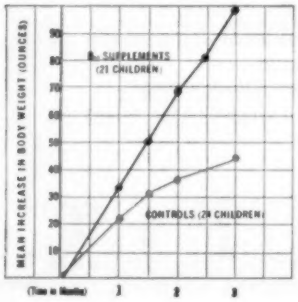
Now there is evidence to suggest that vitamin B_{12} is, or contains, an important human growth factor, or "*HGF*".

Wetzel and his associates[1] found that undernourished children grew much more rapidly on a good diet if vitamin B_{12} was also administered. *Chow*[2] found that in a group of chronically ill children, the experimental group (children who received vitamin B_{12} in addition to a good diet) exhibited a mean gain in body weight practically twice that of the control group (children who received a good diet—without supplementary vitamin B_{12}). This observation was made after three months' therapy with vitamin B_{12}.

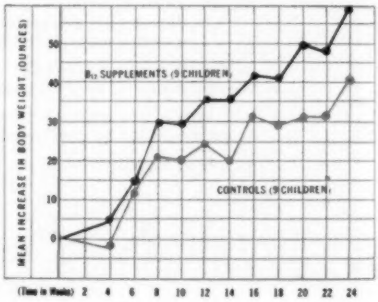
Chow[2] also reported on 18 healthy children in a foundling home. Nine of these children were each given a daily supplement of 25 micrograms of vitamin B_{12}; the other nine received placebos. It was found that the "mean gain in body weight of the children in the B_{12} group was consistently greater than that of the controls from the 4th week onward . . ."[2]

REDISOL® Tablets provide a convenient oral dosage form of vitamin B_{12}. Each tablet contains 25 micrograms of crystalline vitamin B_{12}. REDISOL Tablets are small—easy to swallow. They may be dissolved in aqueous fluids, or added to semisolid foods, just before taking. (Solutions of vitamin B_{12} lose potency if vitamin C is present.)

Growth response in chronically ill children. (After Chow[2]*)*



Growth response in clinically healthy children. (After Chow[2]*)*



Recent nutritional studies on children indicate that Vitamin B_{12} may play an important role in the promotion of growth.

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to stimulate appetite and increase voluntary food intake in infants and children: 1 tablet daily.

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for sprue: 2 to 10 tablets daily for one week or longer, depending on response.

Packaging

REDISOL Tablets are supplied in vials of 36.

1. Wetzel, N. C.; Fargo, W. C.; Smith, I. H., and Heliksen, J.: Growth Failure in School Children as Associated with Vitamin B_{12} Deficiency—Response to Oral Therapy, Science *110*:651 (Dec. 26) 1949.

2. Chow, B. F.: Sequelae to the Administration of Vitamin B_{12} in Humans, J. Nutrition *43*:323, Feb. 1951.

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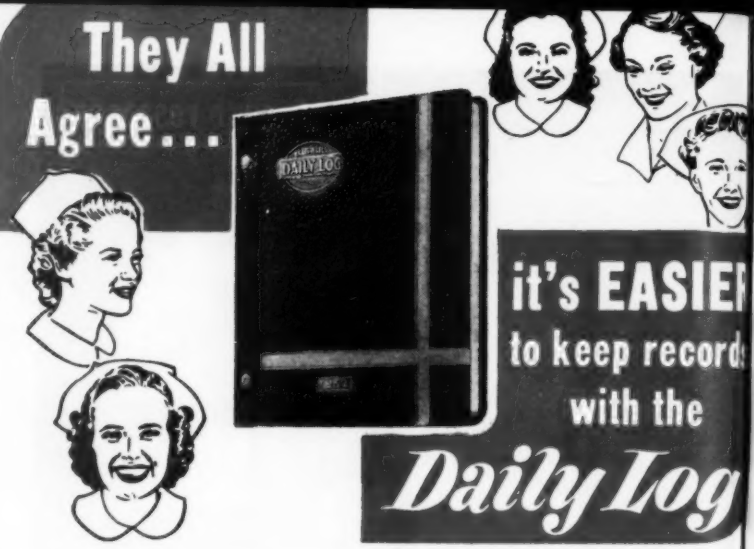

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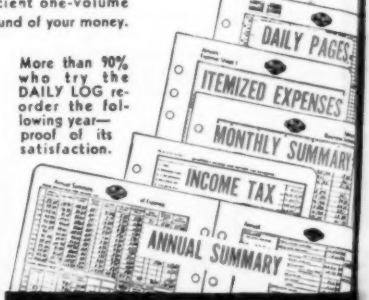

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ment. Unless this is done, the patient may not understand an error in diagnosis or (say) the surface-tissue changes sometimes associated with deep X-ray therapy.

¶ Don't start a hazardous course of treatment without getting a written statement from the patient or someone responsible for him. This statement should specifically express consent to the special treatment.

If all safeguards fail and a suit is started, the physician should remember that his goose isn't necessarily cooked. The mere fact that the patient hasn't progressed favorably, Dr. Regan points out, is no evidence of a doctor's negligence. "A physician is justified if his conduct of the case would be approved by even a respectable minority of his confreres in the same locality."

Nurses, Social Workers To Aid M.D. Training

How can doctors be trained more effectively to give modern health care? The Fourth World Health Assembly has come up with this three-point program:

¶ Let undergraduate curricula play down physics and chemistry, play up psychology, anthropology, and sociology.

¶ Let medical students get to know the surroundings in which the patient lives. "They might, under supervision of a trained social worker, make home visits."

¶ Let doctors and nurses be trained to work as a team, "to study together the total care of the patient."

Want Ewing Plan Limited To Needy Oldsters

The American Hospital Association has indicated willingness to go along with Oscar Ewing's health-insurance-for-the-aged proposal—if benefits are limited to the "estimated 15 or 20 per cent who really need it."

The Ewing plan, of course, would provide sixty days of free hospitalization for *all* people entitled to Social Security benefits. Such a plan would cover an estimated 7 million persons in two years.

The A.H.A.'s official journal attacks this plan as a "small but almost complete package of what its proponents call national health insurance and its opponents call socialized medicine. Beneficiaries are fewer and benefits are limited, but the fearsome mechanism is intact; and this mechanism is the offer of tax-paid (hence seemingly free) service to the rich and poor, the solvent and insolvent, without discrimination. The arguments against compulsory health insurance take many forms, but all revolve around this question: Should the Government try to shower its largess on everybody, or only on the estimated 15 to 20 per cent who really need it?"

If the Ewing forces would revise their thinking on this question, the

With Drilitol* there is no danger from sensitization or resistant organisms.

Drilitol's two antibiotics, anti-gram negative polymyxin and anti-gram positive gramicidin, though highly effective locally, are virtually never used systemically. Thus, there is no danger of sensitizing the patient to—nor of developing in him organisms resistant to—the common antibiotics that may be needed for systemic use in serious infections.

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journal says, they "might be surprised by the ease with which they could get the job done." It continues:

"Suppose they were to recognize the successful opponents of compulsory health insurance, not as a handful of fiendish self-seekers, but as millions of citizens in all walks of life who have deep and honest fears of the consequences.

"Suppose they were willing to have the Government help only those who need help, letting those who are capable of doing so buy their own health insurance.

"Suppose they were to nail this principle to Mr. Ewing's new plan. Who could then argue against a national health program, and what could they say?"

Blood Doesn't Flow So Freely in Siam

U.S. doctors, who administer about 3 million units of whole blood a year, probably never think about being without it. But Dr. Kasarn Chartikavanij, one of twenty physicians from Thailand (Siam) visiting the U.S. on teaching-and-study fellowships, reports that doctors in his country are seriously handicapped by a shortage of blood for transfusions.

Most Thailanders, the doctor says, harbor superstitious fears against giving even one-sixth ounce for a blood test. Result: Out of nearly 1 million people in the capital city of Bangkok, there are only 200 blood donors—most of them anemic from too much giving. For the little whole blood they do get, Bangkok's hospitals must pay a princely sum —by U.S. standards, about $175 a pint.

Kasarn Chartikavanij
Want to get rich giving blood?

Patients Told What Operations Cost

Physicians who happened to scan a recent issue of Better Homes & Gardens could get a good idea of what patients are being told these days about medical and surgical costs. It's a far cry from the old days, when the fees a doctor charged were pretty much his own business.

The magazine listed average fees for thirty-five types of operation, as revealed by a three-year-old survey

of the Equitable Life Assurance Society. These averages, it explained, would serve as a "tangible starting point" in estimating costs. Sample fees listed:

Removal of gall bladder	$194
Caesarean section	176
Appendectomy	131
Delivery of child	78
Humerus, simple fracture	63
Tonsillectomy	41
Broken rib	20

The article then offered patients this four-point program for averting fee troubles:

"1. If your resources are limited, don't overextend yourself by selecting a private hospital room when semi-private or other accommodations are adequate.

"2. When you first talk to the surgeon, volunteer the following information: Your family income, the number of dependents in your family, your fixed expenses (rent, education, and so on), your monthly savings, and your anticipated loss of earnings during the period of convalescence. You will have to volunteer this data, because the great majority of surgeons are reluctant to ask such frank questions.

"3. By all means, find out the fee before the operation takes place. The only legitimate reason for a surgeon not naming his fee beforehand is his ignorance of the patient's circumstances.

"4. If you don't know the surgeon well, don't put yourself completely at his mercy in the matter of fees. Telling him, 'The cost does-

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A MERITENE MILK SHAKE HAS MORE NUTRITIVE VALUE

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Fat	12.8 Gm.	8.0 Gm.
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Ascorbic Acid	4.0 mg.	26.4 mg.
Vitamin D	4 I. U.	150 I. U.
Calories	230	237

*Egg-nog nutritive values from Bowes, A. de P., and Church, C. F.: Food Values of Portions Commonly Used. Philadelphia, 1944; fifth edition.

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A MERITENE Milk Shake supplies 26 per cent more protein and 144 per cent more iron and costs less than an egg nog.

EASY TO PREPARE . . . TASTES GOOD

SUPPLIED: In 1-lb. cans, plain or chocolate flavor, retailing at $1.65 per pound. Also in 5-lb. economy-size cans.

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n't matter—just get my child well,' accomplishes nothing for your child, and the surgeon may take you at your word."

Federal Medicine Doesn't Benefit the Indians

American Indians are wards of the Federal Government. And, says Dr. Haven Emerson pointedly, they live under "some of the worst health conditions in the world today."

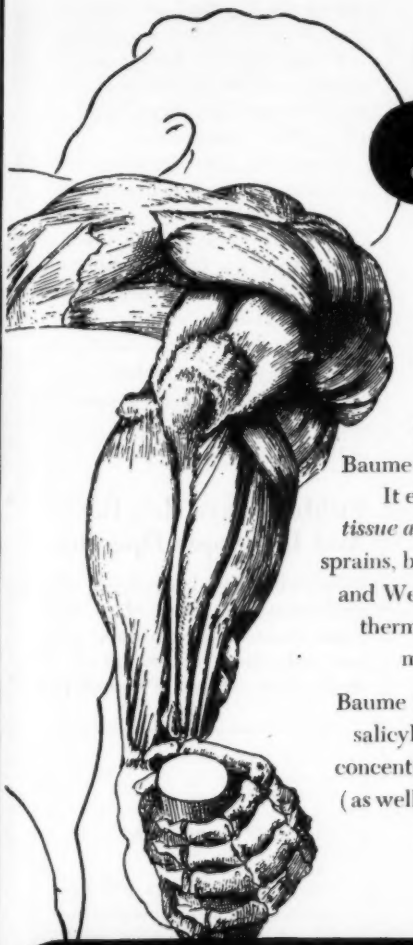
To dramatize the fund-raising campaign of the Association on American Indian Affairs (of which he's honorary president), the plain spoken public health man cites this case in point:

"Last year 260 babies were born to Papago Indian mothers in Southwestern Arizona. Sixty-five of those did not last the year. One hundred of them will not live to see their sixth birthday . . . The death rate of [all] Indian infants is almost four times that of non-Indian children."

What's the reason for this state of affairs? "Penny-pinching and neglect by the Federal Government," says Dr. Emerson bluntly. He promises an all-out fight to get better health protection for the long-suffering redmen.

Small Solace for British G.P.'s

British G.P.'s, who have been largely cut off from hospitals since the National Health Service erupted, got an unexpected crumb thrown their way the other day by the Min-



going deep

The "hyperkinemic" activity of Baume Bengué goes beneficially deep. It enhances blood flow *through the tissue area* in arthritis, myositis, muscle sprains, bursitis and arthralgia. As Lange and Weiner[1] determined by the use of thermo-needles, hyperkinemic effect may extend to a depth of 2.5 cm.

Baume Bengué also promotes systemic salicylate action. It provides the high concentration of 19.7% methyl salicylate (as well as 14.4% menthol) in a specially prepared lanolin base to foster percutaneous absorption.

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ANALGESIQUE

1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.

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BB-50-A2 (R)

istry of Health. Said the Ministry: "It is desirable, wherever possible, that some maternity beds in suitable hospitals should be put at the disposal of general practitioners for the care of their own patients."

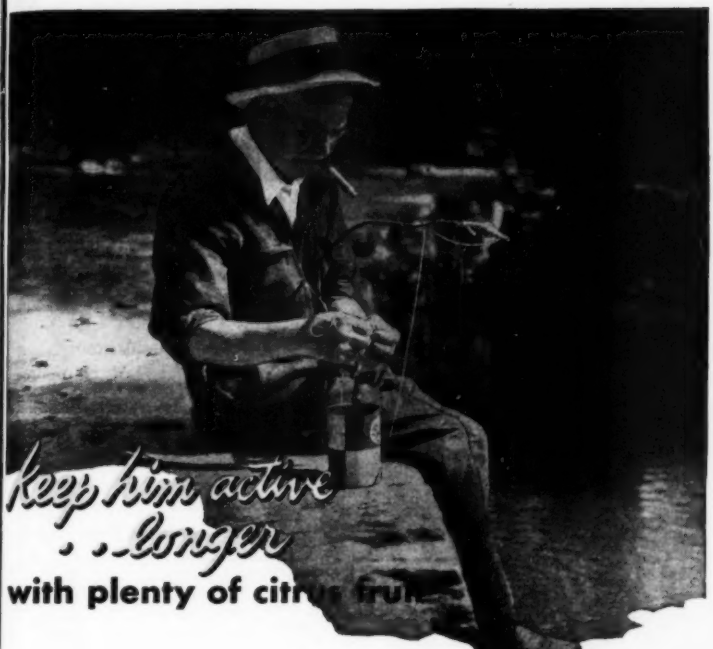
Before this, hospitalized cases automatically came under the care of staff specialists. But the new recommendation won't mean any big windfall for the G.P.'s. Added the Ministry: "Such beds would have to be excluded from those available for the training of pupil midwives in a midwifery training school." Hospitals, it warned, must consider the needs of midwives-to-be as well as of the G.P.

Fishbein Says He's Bookie And Burlesque Operator

Asked what he'd been doing since graduation from Harvard in 1948, Justin Mantel (son of Morris) Fishbein submitted for his triennial class report a sketch of himself that

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice. Address Medical Economics, Rutherford, N.J.



keep him active . . . longer

with plenty of citrus fruits

As at the other end of the age gamut, optimal nutrition can make a tremendous difference in the vigor and stamina of the oldster.[1,8,9-11] Many geriatricians stress the importance of vitamin C in the management of geriatric diets,[2,5,9] and recommend a fully adequate intake[5,9] of citrus fruits and juices (so often neglected by older people)—because of their high content of this essential vitamin and of other nutrients. Fortunately most everyone likes the taste of Florida citrus fruits and juices. They may be served in a variety of ways, and—under modern techniques of processing and storage, whether fresh, canned or frozen—they can *retain their ascorbic acid content,*[3,7] *and their pleasing flavor,*[4] *in very high degree and over long periods.*

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Citrus fruits—among the richest known sources of Vitamin C—also contain vitamins A and B, readily assimilable natural fruit sugars, and other factors, such as iron, calcium, citrates and citric acid.

References:

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succeeded in catapulting fellow alumni out of their well-upholstered armchairs.

"After graduation" he said, "I tried several jobs but did not succeed in any of them. One of the contacts I made, though, later bore fruit in the offer to open a small handbook [the wagering kind] on the west side of Chicago.

"It has been very successful, and I now operate other types of gambling as well.

"Up front, we run a small burlesque show. And, believe it or not, the payoff to the cops is only $200 a week."

Fellow alumni have since learned that Fishbein's real-life occupation (reporter for the Chicago Sun) is considerably more prosaic. Not only has he no plans to enter the bookmaking or the burlesque business, but he's described by his fellow workers as "a model of decorum and sobriety."

Blue Shield Boosting. Fees Paid to M.D.'s

Average Blue Shield payments for medical and surgical services in the hospital have gone up 45 per cent in one year. This reflects a growing liberalization of benefits among the physician-sponsored plans, say Blue Shield officers in revealing the boost.

After its first year of maintaining complete statistics, Blue Shield reports that the average in-hospital medical claim paid rose from $24 in

May 1950 to $32 in April 1951. During the same period, surgical claims paid went from a $37 average to $53.

Obstetrical coverage remained unchanged in most plans. Blue Shield's average cost for OB benefits rose only from $57.92 to $58.56 during the twelve months covered by the survey.

Third of British Want To Leave England

Ever get an urge to leave the U.S. and practice in another country? Probably not. But if you lived in Socialist England, there's a good chance you'd want to try something else.

The British Institute of Public Opinion recently asked a cross-section of Britain's population this question: "If you were free to do so, would you like to go and settle in another country?" The answers broke down this way:

Yes	33%
No	61%
Undecided	6%

New Surgical Board Called Deplorable

Setting up duplicate boards of certification—as proposed recently by the International College of Surgeons—is "deplorable." It's the kind of competitive activity that "can only confuse the profession and confound the public." Such is the verdict of the New England Journal of Medicine, which warns that the

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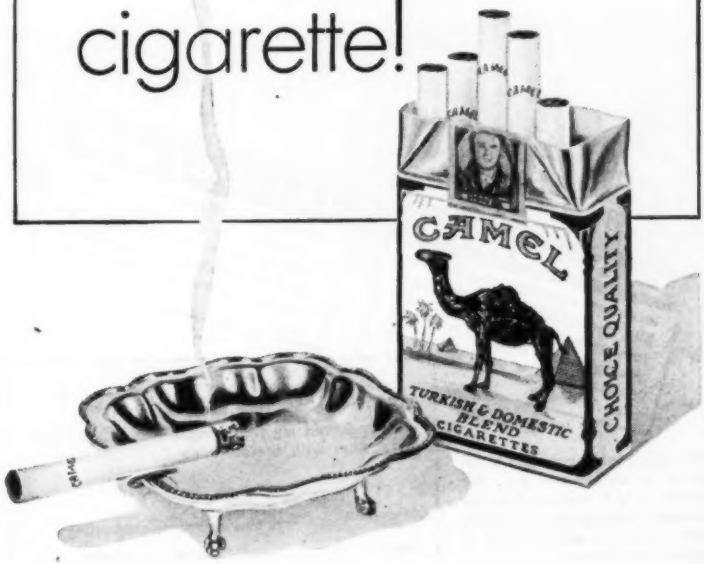

I.C.S. example may breed other independent boards.

"As is well known," says the journal, "there is already a board of certification in surgery—the American Board of Surgery, incorporated in 1937, created [through] the Advisory Board for Medical Specialties, and approved by the [A.M.A.'s] Council on Medical Education and Hospitals." This board, which "represents a fair cross-section of American surgery," has a two-fold purpose: "First, to certify those surgeons found to be qualified after meeting reasonable requirements; second, to improve existing opportunities for training."

"It may be that its target has been too high, or even too low. But correction of this should come from within the framework of the advisory board and not by the creation of independent boards mushrooming within a single society, which may become a disservice to American medicine."

Sees Medical Students At Odds With M.D.'s

"Organized medicine and the medical students are talking entirely different languages." That's the conclusion of William Bender, campus organizer for the new Student American Medical Association. He bases his opinion on his experiences at the University of California.

Not only are a majority of the university's seniors "for socialized medicine in one form or another";

for injections without objections

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they are severely critical of the A.M.A. Comments Bender: "In presenting the S.A.M.A. to the students, I happened to mention the American Medical Association. I want to tell you that I was very vigorously booed. That is the way the students feel about it at Cal."

Reason for the students' anti-A.M.A. stance, according to Bender: Its action is never positive, only negative—"at least that's what the students think."

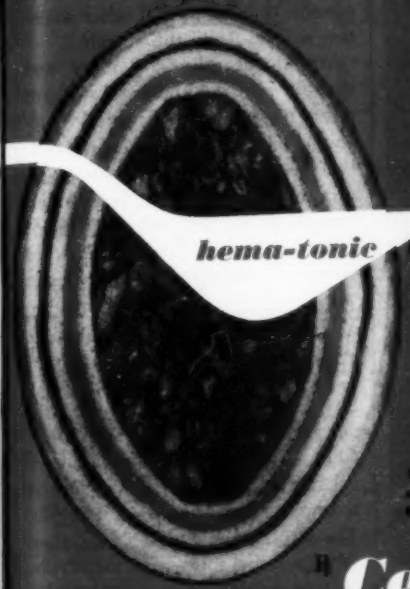
And why the leaning toward socialized medicine? That's a hard one to pin down, Bender admits: "I think the main reason is that the national trend (and the world trend) is toward socialization. These future doctors are part of that trend."

Socialist ideas are strongest among juniors and seniors, he feels. This stems perhaps from their visits to San Francisco's County Hospital. "Seeing those poor people there getting the kind of treatment they do, the sympathy just comes out—even though that is a form of socialized medicine . . ."

Despite the difficulties of bucking this trend, Bender reports that the student medical association at Cal has signed up 120 members out of a possible 150.

Diabetes Drive Enlists Record Medical Help

An all-time high in physician cooperation is forecast for this year's Diabetes Detection Drive, to be staged November 11-17. Partici-



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Riboflavin	2.0 milligrams
Pyridoxine Hydrochloride	0.5 milligram
Nicotinamide	10.0 milligrams
Ascorbic Acid	25.0 milligrams

Dosage: Average Adult — 3 tablets daily
Children — from 1 to 3 tablets daily

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pants include more than 500 county and twenty-eight state medical societies that have active diabetes committees. Some 200 other societies will also join the search.

Americans who are obese and over 40 will get the biggest share of attention. They're believed to account for large numbers of the million people who have this ailment without knowing it. Since more women than men are so afflicted, special promotion is being aimed at women's groups.

Want to Get Started in Industrial Medicine?

Since a certain small-plant health service was set up in Hartford, Conn., it's had five different medical directors. The first man left in ten months for a top university job. The second man stayed a year, then got a salaried job with a large rubber company. The third M.D. worked two years and then joined a state agency in charge of employe health. The fourth went to a large chemical company after three months. The fifth man is still there.

This case history, says the American Public Health Association, shows how the enterprising physician can use small-industry health work as a springboard to "positions offering more stability, greater opportunity, and better financial return."

Right now, the A.P.H.A. journal reports, the field is wide open. Although half the nation's working population is in small plants, less

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than 1 per cent (or fewer than 100,000 workers) are believed to have adequate health programs.

Many successful small-plant services—like those in Minneapolis, Philadelphia, Portland, and Burbank—were started by private practitioners. An ideal framework for new industrial programs, adds the journal, may be found in "existing group practice units, particularly if combined with prepayment (as in the H.I.P. plan of New York) or with new units created specifically for . . . in-plant health services."

Doctor Dossier Speeds Emergency Service

A complete dossier on each physician's daily habits helps the Columbus (Ohio) Academy of Medicine fill emergency calls at a 300-a-month clip. When signing up for this service, each M.D. makes out a card that tells, among other things, where he eats lunch and dinner; what clubs he frequents; what nights he visits friends; and what relatives are apt to know his whereabouts. With this information on hand, the switchboard girls nearly always get their man. Even so, it takes an average of four calls per emergency.

The Patient That Nobody Wants

Apparently the laws and regulations that go with Britain's National Health Service haven't done much about erasing the problem of the problem patient. The N.H.S. exec

All the Facts

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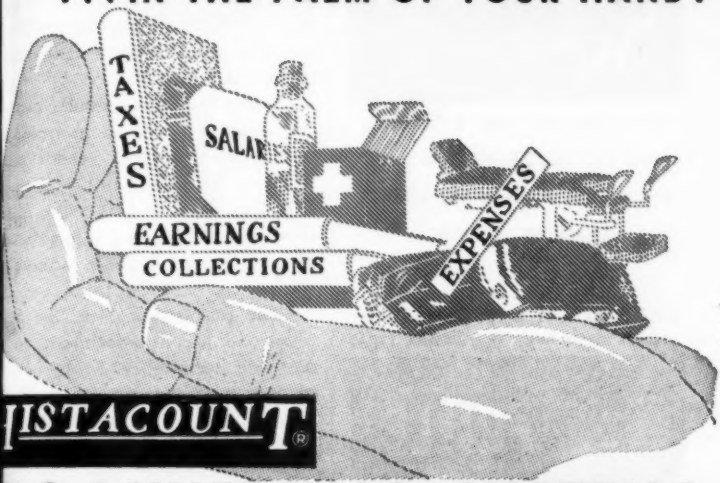

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utive councils, at any rate, are trying unsuccessfully to cope with a problem patient they consider the mother of them all.

During one three-month period this year, the woman in question was assigned to four practitioners in a row. She asked to be removed from one doctor's list; the other three physicians asked to be relieved of her. One physician's request to the N.H.S. read like this:

"The purpose of Mrs. X's telephone call was to order me to come and visit her at once. In the course of the conversation, she made it clear that she had no intention of ever coming here and 'waiting in any stuffy waiting room,' on this or any future occasion, and that I must at all times visit her when she thought fit to send for me. In these circumstances, I must respectfully decline the honour you have bestowed upon me by placing her on my list, and ask that her name be now removed."

At last reports, the London executive council was at wit's end trying to find an unsuspecting physician on whom the woman could be pawned off. Complicating the problem was the fact that both patients and doctors have conflicting rights under the N.H.S.: the patient, to be placed on some physician's list; the doctor, to refuse the patient.

The Medical World, published in London, offers this advice to the doctor who is eventually saddled with the problem patient: Remember "the salutary effects of *Mist. Asafoetida* in large and frequent doses

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Memo from the Publisher

● Ever wonder how your reading habits compare with those of your colleagues?

At least where MEDICAL ECONOMICS is concerned, we can give you a yardstick. It's based on some recent depth interviews, conducted among a random sampling of several hundred physicians from coast to coast. The aim: to find out exactly how America's medical men go about reading a magazine like MEDICAL ECONOMICS.

If you're typical of the men surveyed:

You do your reading at the office—between patients, in slack periods, or at the end of the day. The great majority of all doctors interviewed described this as their set professional-reading pattern. Some 40 per cent, however, also take MEDICAL ECONOMICS home with them.

You turn first to the table of contents and pick out the articles you're most interested in. But nearly everyone also leafs through the magazine, pausing over other features that catch the eye—particularly letters to the editor, picture stories, editorials, anecdotes, and cartoons.

You return to each issue several times. Only 20 per cent of the doctors surveyed finish M.E. in one sitting. Two-thirds pick it up three times or more, one-third pick it up five times or more. (It's hard to believe, but one of the M.D.'s interviewed insisted that he returns to each issue an average of thirty times.)

You find that reading is habit-forming. The great majority of all doctors surveyed said they never miss an issue, read at least half the articles every time MEDICAL ECONOMICS comes out.

Naturally, such findings are useful to us. They help us tailor future issues to fit the reading patterns revealed. We've even found it worthwhile, periodically, to sponsor a year-long series of readership studies. These are conducted for us by Roy Eastman, one of the country's top hands at the business.

Results cannot be used promotionally; they are for no other purpose than helping us turn out a better magazine. But we would be less than human if we failed to add that we're increasingly gratified by his findings.

There's no greater publishing incentive, after all, than an interested reader audience. So if MEDICAL ECONOMICS has become part of *your* reading habits, we're both gratified and grateful. —LANSING CHAPMAN